Rocky Mountain Medical Journal

Title Registered, U. S. Patent Office

Publication Office

835 Republic Building, (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 2-0547

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a non-profit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

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VOLUME 53 **NOVEMBER, 1956** **NUMBER 11**

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VOLUME 53 **NOVEMBER, 1956** **NUMBER 11**

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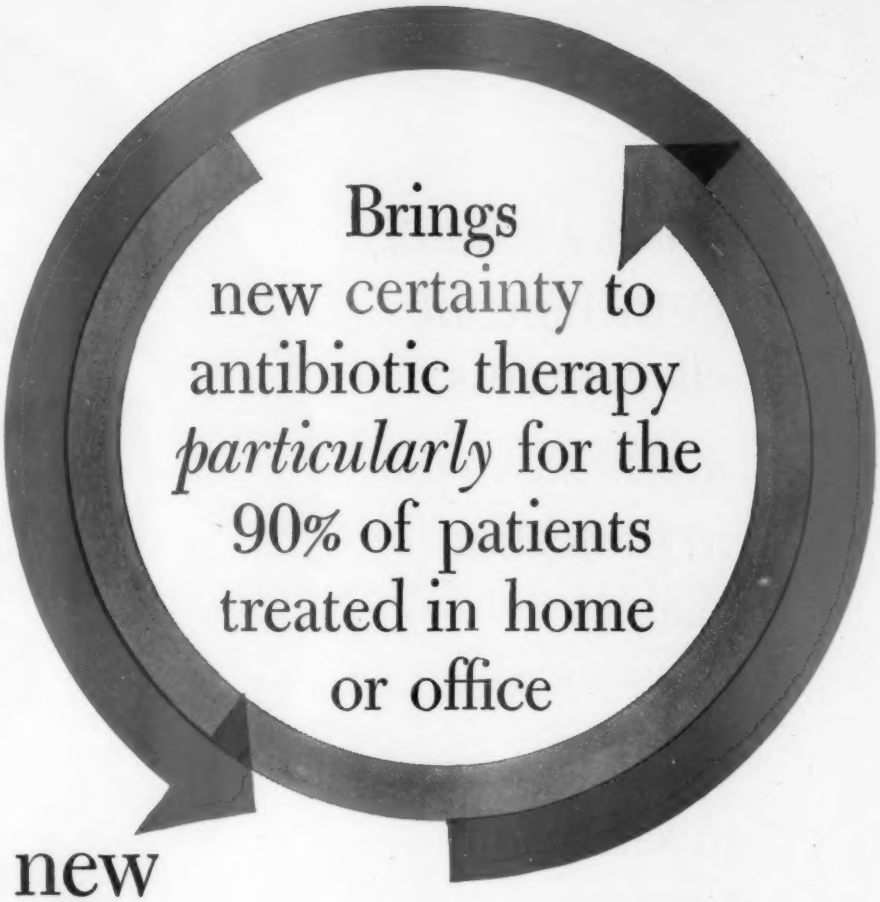

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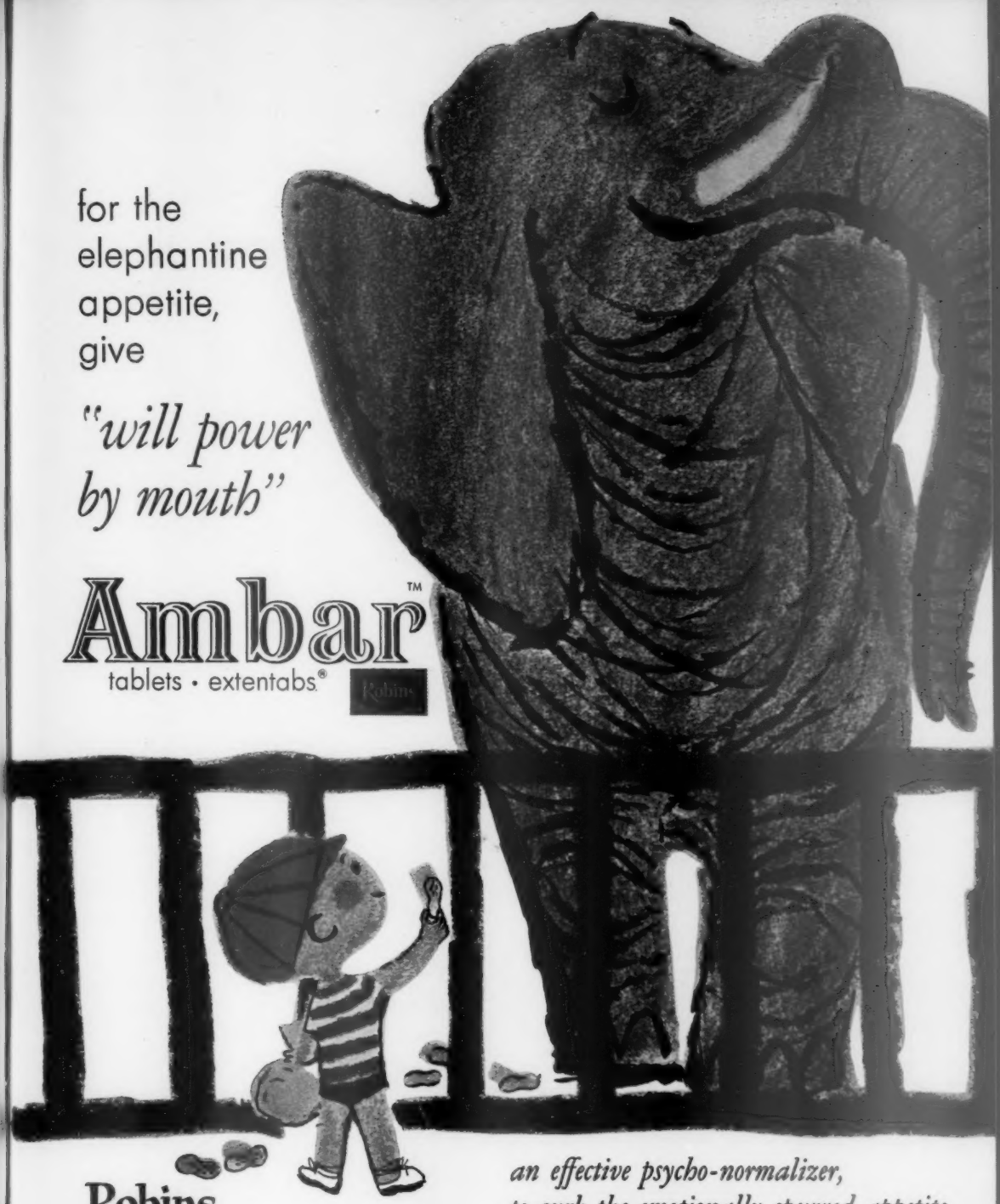

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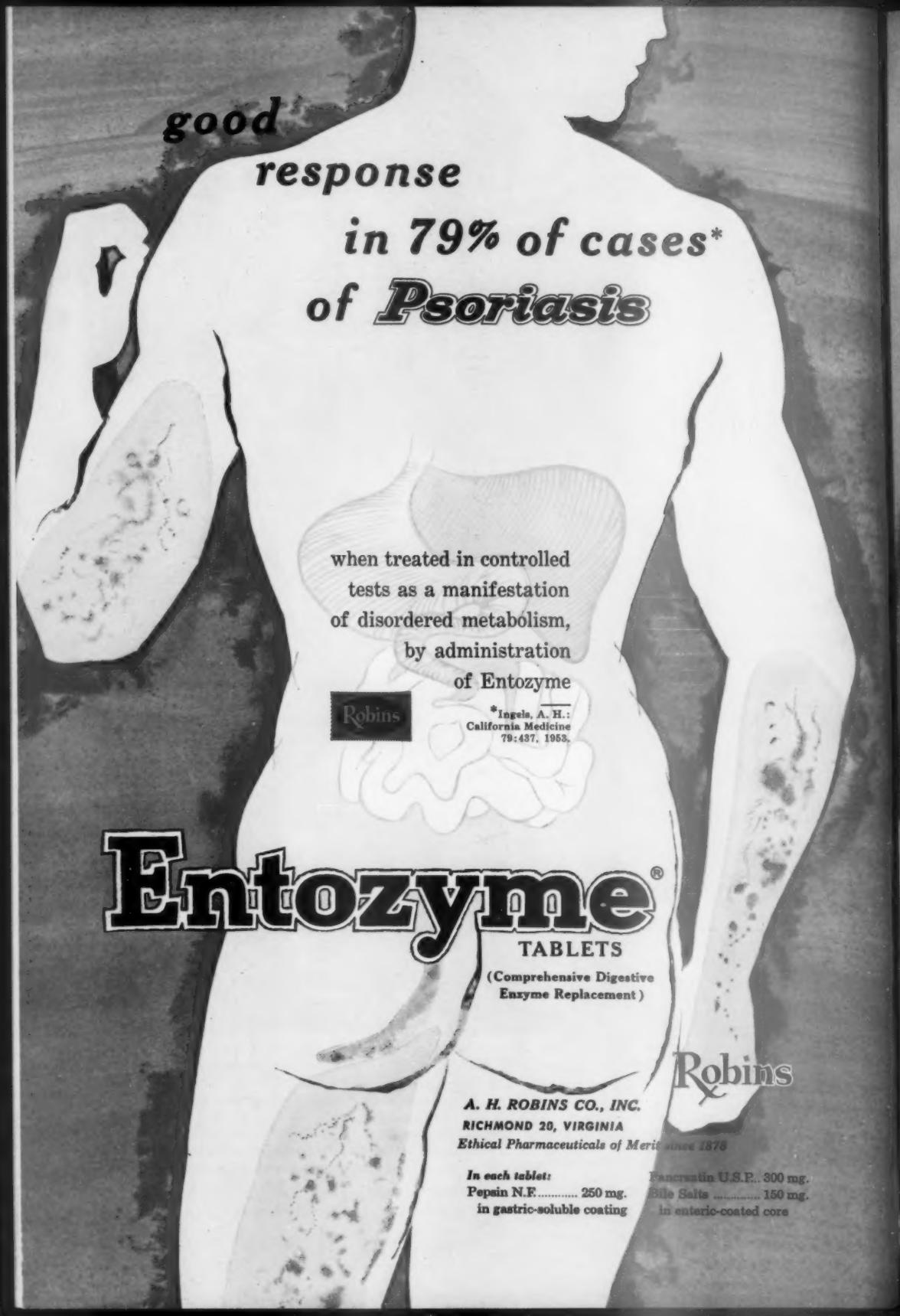
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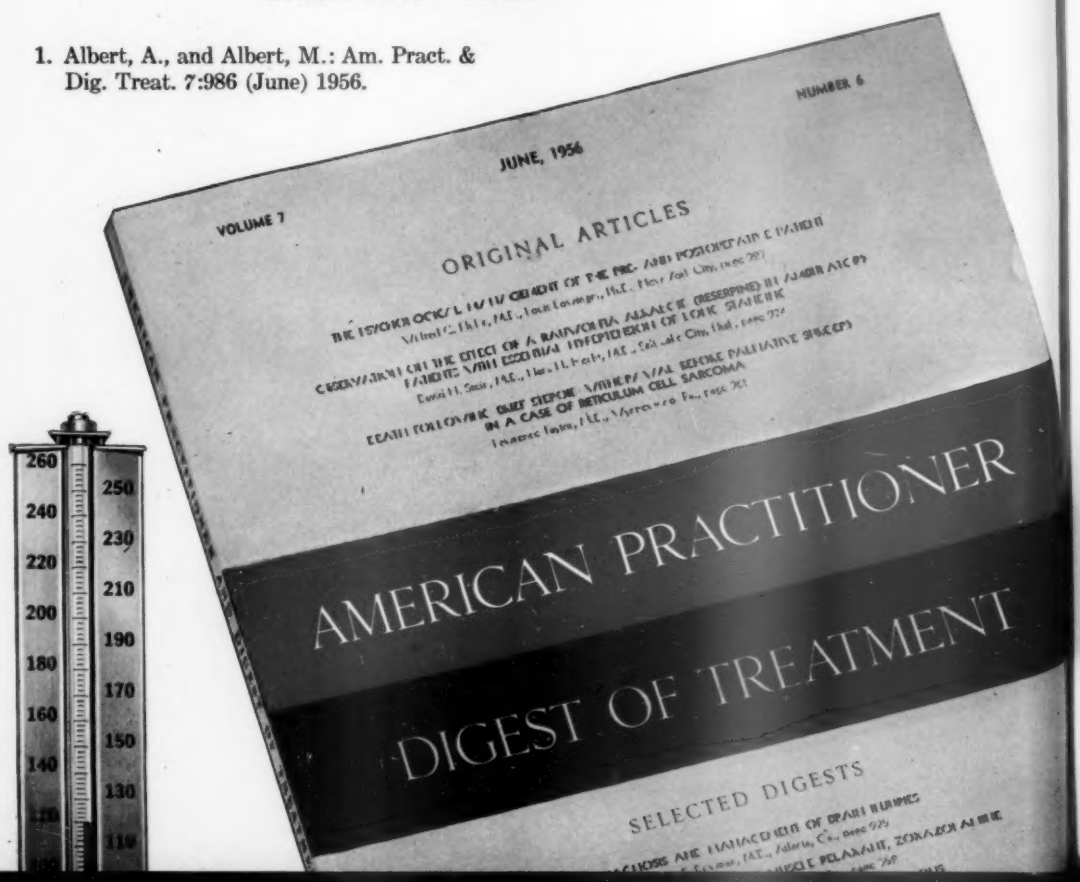
1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



Meat...

Good Nutrition and Endocrine Functioning

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1. Ralli, E. P., and Dumm, M. E.: The Hormonal Control of Metabolism, in Wohl, M. G.: Modern Nutrition in Health and Disease, Philadelphia, Lea and Febiger, 1955, pp. 57-74.
2. McHenry, E. W.: Nutrition and Endocrine Function, Borden's Review of Nutrition Research, *16*:17 (Mar.-Apr.) 1955.
3. Ershoff, B. H.: Conditioning Factors in Nutritional Disease, Physiol. Rev. *28*:107 (Jan.) 1948.
4. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, University of Minnesota Press, 1950.
5. Samuels, L. T.: Progress in Clinical Endocrinology, New York, Grune and Stratton, 1950, p. 509.

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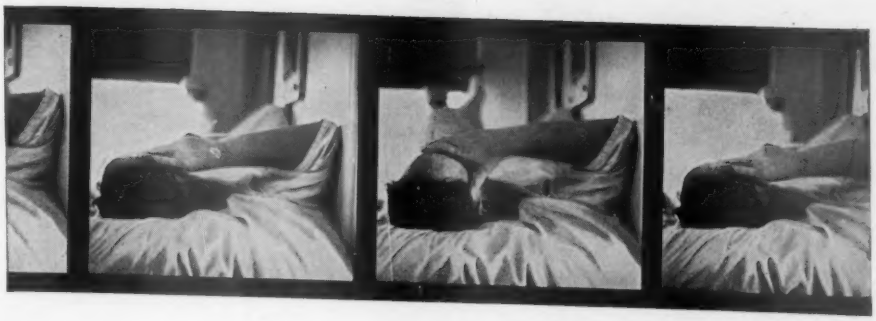

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1. Mathews, Morris and Moyer: Am. Pract. & Dig. Treat. 6:360 (Mar.) 1955.

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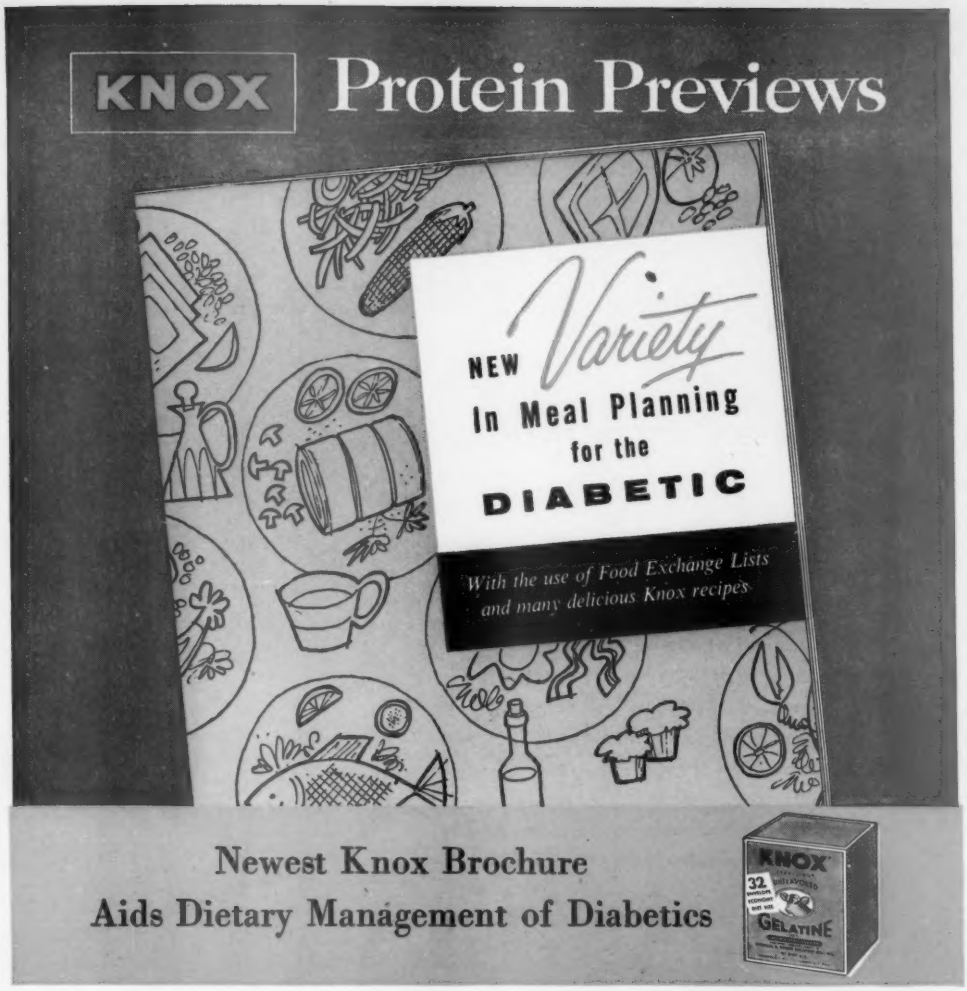

Although more than 50% of diabetics can be managed with proper diet, continued success is dependent upon proper motivation of patients. Determination to abide by dietary restrictions is also important for the diabetic being managed with insulin.

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EDITORIALS

Opportunities For Physicians

DISTRIBUTION of physicians throughout Colorado or any of the western states, especially those comprising the Rocky Mountain area, is irregular. If statistics of "physician-to-population" are used as a unit of comparison, it will be found there is a proper ratio, but if "physician-to-square-miles" is the unit, then one becomes aware of an apparent paucity of doctors.

Communities which had several physicians practicing in the area a generation or two ago, now find themselves without a doctor. Basic facts must be presented to explain this situation. This is no longer an era of horse transportation. Excellent highways connect towns and cities so the patient can secure attention more rapidly. Towns which at the turn of the century had a population of several hundred are now inhabited by only a few families, making it impossible for a physician to make a livelihood there. Hospitals are a *must* these days and, as they can only be maintained by an adequate patient load, it is essential they be placed in areas which are properly populated.

Why do physicians not locate in the small towns? Young physicians are required to go to college for a minimum of seven years; there is a year of internship and then there is the required military service to be served. These figures add up to ten years, and still no graduate training has been allowed. These physicians are biologically normal, so have married and have fathered children to be educated. Naturally, a physician will start practice where he can make his living early and also give his family cultural and educational advantages not obtainable in less densely populated areas.

There must be a compromise somewhere in problems outlined above. Young physicians should look to some of the smaller communities for establishing practice. A good living will be made from the start and, at the end of a five-year period, physicians will have acquired more of both material and immaterial things in a rural community than colleagues who have dedicated their lives to larger cities.

Income sources of the Rocky Mountain area has changed materially during the past half century. In the past, mining and health seekers constituted a major part of revenue. As these two decreased, fortuitously, more land was made available for agricultural returns through increased irrigation. Geographically, this resulted in relocation of families from mountainous districts to the plains and flatter areas or valleys between mountains. However, the fewer families preferring to maintain homes in the hills still require medical attention, and for these people physicians must be provided.

During recent years the lack of water from both rain and irrigation has caused an economic crisis to arise. Farms have been abandoned, and laboring families have had to move elsewhere. Thus through reduced population and income medical men have hesitated to settle in these communities. This creates a unique situation as there are known instances of community hospitals which are faced with closing or have closed because of lack of physicians to staff them. All of this boils down to the question of how shall the problem of distributing physicians to needed areas be met. First, each community must appraise itself critically to determine just how badly it needs a physician; then, what can it offer to highly trained men in non-professional activity (churches, schools, clubs, social life) which will induce them to live in the community.

Also, young graduates must study themselves to evaluate what they owe their fellow men and the state. The practice of medicine is truly a humanitarian vocation, and rare indeed is the young person who goes into the profession solely for financial

remuneration. There is an indescribable ideal which makes a student consider medicine, for everyone knows the sacrifices entailed in practicing it. However, obtaining his degree is not entirely the result of his own financing, his family's, or the G-I bill. There are no medical schools in the United States where tuition paid by the student covers the entire cost of his education. All the schools are established and maintained through taxation or from income of large amounts of money given in previous years. Thus, people living in outlying areas have subscribed to his education and are entitled to consideration of their needs.

We, as an organized group, must insist as far as practicable upon insuring medical attention being furnished where needed. This can be done by encouraging young physicians to accept the opportunities afforded to settle in areas needing their services, and by subtly suggesting that persons in such areas who want physicians shall make those communities attractive enough to induce the young physicians to come, serve, live, and "grow up" among these fine people!

HERMANN B. STEIN.

What Does "Blue Shield" Mean to You?

HAVE you ever stopped to ask yourself, doctor, why some 37 million Americans have enrolled in Blue Shield, the medical profession's own approved prepayment program, in a little more than ten years' time? Blue Shield and its companion, Blue Cross, have accomplished the most stupendous enrollment of any insurance program ever offered the American people—at a minimum of expense and by relatively "low pressure" sales methods. This accomplishment has been possible because there is now an almost universal desire for protection against the costs of unpredictable illness. The chief reason why so many people have chosen Blue Shield is that they know it is recommended and supported by the medical profession, and most people have confidence in the nation's doctors.

By the same token, more Americans have chosen Blue Cross than any other hospital insurance program because Blue Cross is sponsored by the hospitals, and the public believes in the integrity and efficiency of our voluntary hospital system. Doctors and hospitals have created for themselves an immeasurable store-house of good will in these Plans. But the preservation of this great asset depends upon eternal vigilance on the part of physicians and hospitals. When the doctor speaks well of Blue Shield, when he renders the best service he is capable of rendering to Blue Shield patients, when he tries to conserve the resources of Blue Shield against extravagance and abuse, when he conscientiously fulfills his voluntarily accepted obligations as a Participating Physician, then he is helping to preserve and increase this asset. He is helping to make ever more formidable the shield that protects the freedom of medical practice.

Blue Shield is also a bridge of common interest and mutual benefit between the doctor and his patient—it is evidence to each of the trust and confidence of the other. Blue Shield is an assurance to the patient of prepaid service when he needs it—and to the doctor, it assures prompt reimbursement for his services.

Dermatitis From Chlorpromazine

THE Colorado State Department of Public Health calls attention to the fact that an increasing number of cases of occupational dermatitis is being reported among nurses who handle chlorpromazine (thorazine) in the course of their daily duties. This substance is evidently highly sensitizing and, as would be expected, most commonly affects the hands. Physicians, nurses and others, particularly those inclined to be allergic, who prepare and administer chlorpromazine should protect their skin from exposure to the drug. The occurrence of a dermatitis among such individuals should lead immediately to the suspicion of chlorpromazine allergy.

Editor's Note: Be sure to read the special article on Principles of Medical Ethics, Pages 1084-1085 *of this issue.*

ARTICLES

Indications for Adenoid And Tonsil Removal In Children*

Shirley Harold Baron, M.D.
SAN FRANCISCO

Adenotonsillectomy is an important operation with definite indications, contraindications and pitfalls. This plea for more meticulous technic is a timely and progressive contribution.

ADENOTONSILLECTOMY in children has been a subject of much discussion and abuse. Discussion has been warranted in that the condition of tonsils and adenoids in children is an important factor in present and future health. Abuse lies in the fact that too many cases are being done with flimsy, rationalized indications, and that in too many cases surgical technic is deficient. Regrowth of tonsil tissue due to incomplete surgery has been reported as high as 68 per cent; incidence of adenoid recurrence is probably even higher. Therefore, and since adenoid and tonsil surgery constitutes from one-third to one-fourth of all surgery done in the United States, a plea for better technic is in order.

It has been stated that gradual improvement in the health of children, as reported in statistics of the United States Children's Bureau, is due in part to removal of infected, hypertrophic tonsils and adenoids. There is considerable truth in this statement, but it should be emphasized that every child scheduled for adenoid and tonsil surgery is a calculated surgical risk. Therefore, it is important that the indication for surgery be beyond question and the risk be reduced to absolute minimum by having precise, clean, complete technic that will minimize the hazards, accomplish the objective, and eliminate need for re-operation.

Tonsils and adenoids play an important role in development of auto-immunization in the young child. However, when infection gains the upper hand and tonsils and adenoids are no longer able to fulfill their protective function, or when complications such as middle ear disease, become of greater importance than whatever protective function may be left, adenoids and tonsils should be removed. Age should **not** be a consideration. Adenoids and tonsils may cause trouble at any age and therefore should be removed at any age if indication is definite and important. By the same reasoning, tonsils should never be removed at any age if they have not shown evidence of trouble.

There is no definite season for adenotonsillectomy. Any season in which there is no epidemic of any kind is the right season. Despite the controversial relationship of tonsillectomy to poliomyelitis, the surgery should not be done in the presence of any epidemic. When should adenotonsillectomy be done in children who are being immunized by the Salk vaccine? It has been stated, "If it is desired to derive what

*From the Department of Surgery, Division of Otolaryngology, Stanford University Medical School, and the Department of Otolaryngology, Mt. Zion Hospital. Presented before the Twenty-First Midwinter Clinical Session, Colorado State Medical Society, February 14-17, 1956.

protective influence vaccination may provide before tonsillectomy, then the period when the full protective effect can be antipicated from primary immunization would be 14 days after the second dose, even though it has been shown that in the majority of individuals antibody develops 14 days after the first dose." If it is urgent that adenotonsillectomy be done between doses, there is no contraindication.

Some pediatricians request that adenoids be removed without removing the tonsils in very young children. Some otolaryngologists agree with this request because of feeling that compensatory hypertrophy of lymphoid tissue of Waldeyer's ring is less with adenoidectomy alone. My own belief is that this hypertrophy occurs mainly in allergic children. In only rare occasions have I removed adenoids without removing tonsils. Even in very small children, when there is indication for adenoidectomy, there is usually indication for tonsillectomy. These children have not shown lessened resistance to infection following surgery. Actually their resistance, as well as development, has improved.

Some of the clear-cut indications for removal of adenoids and tonsils are:

1. Conduction deafness, with or without otitis media.
2. Recurrent episodes of acute purulent otitis media.
3. Chronic otitis media.
4. Nasopharyngeal obstruction causing mouth breathing.
5. Suppurative sinusitis, recurrent or chronic.
6. Breathing difficulty due to mechanical obstruction of both adenoids and tonsils.
7. Repeated attacks of acute tonsillitis with fever and malaise and other systemic effects.
8. General underdevelopment associated with repeated attacks of adenotonsillitis or excessive adenotonsillar hypertrophy. Particularly, in this group, are youngsters who have underdeveloped chests associated with nasal obstruction.
9. Chronic or recurrent cervical adenopathy.
10. Speech defects associated with excessive adenoid and tonsil hypertrophy.
11. History of peritonsillar abscess.
12. Foul breath due to collection of debris in the tonsillar crypts.
13. Diphtheria carriers.
14. Prophylactically in cases with congenital cardiac defects.

There are other indications less clearly defined. Johnstone and Watkins reported improvement following adenotonsillectomy in 10 of 16 children who had had bronchitis, in 64 of 72 patients who had abdominal pains associated with throat infections, in 121 of 144 patients with anorexia, and in 8 of 10 patients who had infectious arthritis.

Despite opinions to the contrary, there are still those who believe focal infection of tonsils and/or adenoids may cause pyelitis, nephritis, septicemia, arthritis and other serious illnesses. Eley stated there has been no proof advanced to support relationship between infected lymphoid tissue and such conditions as rheumatic fever, chorea, nephritis and nephrosis, but it is believed, however, that patients with congenital heart disease may have severe complications, such as subacute bacterial endocarditis, as a result of infection of lymphoid tissue. At Stanford it is a rule to do prophylactic adenotonsillectomy on any patient with a congenital cardiac anomaly, especially if a surgical cardiac procedure is planned. These patients do well during the adenotonsillectomy probably because they get a higher oxygen saturation with the oxygen-ether insufflation than in their usual state. They are given ample antibiotics before, during and after surgery. No anesthetic or bacterial complications have occurred in any of this group.

Some contraindications to removal of tonsils and adenoids are:

1. The presence of an epidemic of any kind.
2. The presence of any recent acute infection in the patient.
3. A history of bleeding (the history is a much better aid than the laboratory tests).
4. Anemia.
5. Any systemic disease that will render the patient a poor surgical risk.
6. Allergies in some patients.

Removal of tonsils and adenoids in an allergic patient without previous history

of asthma has been known to precipitate an attack of asthma. There are allergic children, however, who are badly in need of an adenotonsillectomy. When surgery is done for these patients, it should be done in consideration with therapy for the allergy. It must be remembered that, in an allergic patient, there may be recurrence of lymphoid tissue in the tonsil fossae, lateral walls of the pharynx and nasopharynx even with the most thorough technic. This is, however, the only justifiable excuse for recurrences.

In recent years there has been an increasing number of conduction-deafened children, especially in the preschool age, with or without serious otitis media. The onset of the deafness in many of these cases is insidious and goes unrecognized, and the child may give the impression of being mentally retarded or stupid. Early investigation of hearing in these youngsters is important because in most instances the deafness is reversible by a **thorough** adenoidectomy; a "hop, skip and jump" adenoidectomy will not do. It has to be thorough with removal of all lymphoid tissue around the eustachian tube orifices and from the tori, if necessary, and on the salpingopharyngeal folds. There is no substitute for good surgery in these cases. X-ray or radium therapy will not accomplish as much for as long as thorough surgical adenoid removal.

CASE REPORT

P. C., a 7½-year-old boy, was seen on November 18, 1954, because of deafness which had been present for at least a year and was gradually becoming worse. His ear trouble started within two weeks after birth. Because of continued recurrent attacks of suppurative otitis media, he was given x-ray therapy to his nasopharynx at 1 year of age. Ear symptoms abated for about six months and then recurred, and at about 2 years of age, he was given another course of x-ray therapy to his nasopharynx. Ear symptoms stayed away for another six months and again recurred. At age 3½ adenotonsillectomy was performed. This kept him symptom-free for seven months when attacks of ear trouble reappeared. They occurred less frequently, but hearing impairment was noted at about the age of 6.

Physical examination revealed thickened, gray, retracted tympanic membranes in both ears and severe conduction deafness with an average decibel loss for the conversational range of approximately 35 for each ear (Fig. 1). The 30 decibel threshold is a minimal serviceable hearing threshold. Increased hearing loss above this threshold seriously interferes with word communication and explains why this child was having difficulty in school. The nose showed a typical picture of vasomotor rhinitis associated with allergy. The nasopharynx, which was examined with a nasopharyngoscope, showed abundant regrowth of adenoid tissue on the lateral walls of the nasopharynx and in the central vault as well. Lymph tissue follicles were present in each tonsil fossa.

Surgery was done on December 3, 1954, and a large amount of adenoid tissue was present in the areas described (on physical examination) and on each eustachian tube torus. This tissue was thoroughly removed under direct vision with curettes and punches. Bilateral myringotomies were done and in each ear was found thick, gray, stringy, gelatinous fluid which was so

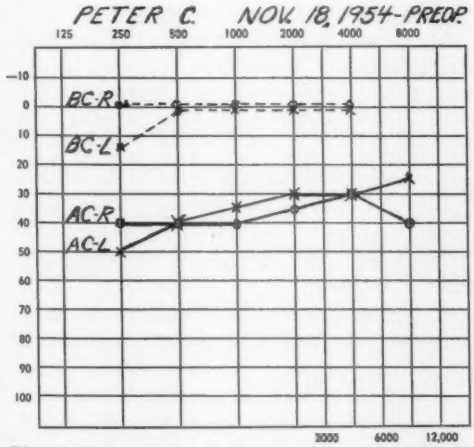

Fig. 1. Pre-operative audiogram of case reported.

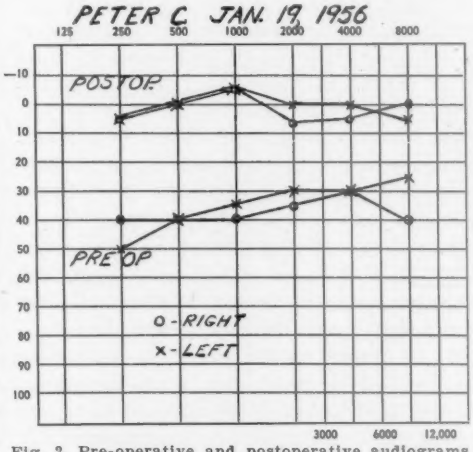

Fig. 2. Pre-operative and postoperative audiograms of case reported.

sticky that it was difficult to aspirate. (In some cases where this sticky fluid is present, I make a tympanic membrane incision in the posterior inferior quadrant and in the anterior inferior quadrant, in order to get all the fluid out. These incisions do no damage to the tympanic membrane; they heal rapidly.)

There was immediate hearing improvement to about the 15 decibel level after surgery. Repeat audiograms were done at monthly intervals, and by June 17, 1955, hearing returned to normal level. The last audiogram, done on January 19, 1956 (Fig. 2), shows the left ear at the normal level with the right ear at a nearly normal level.

Comment

This case is presented because it summarizes points of importance which are as follows:

1. Irradiation therapy to the nasopharynx, particularly in an allergic child, may be of therapeutic benefit which, in most cases I have seen, is only transient. Since irradiation therapy is of limited therapeutic value in this kind of case, there is some question as to the wisdom of subjecting such a small patient to irradiation, especially in the light of undesirable late sequellae as mentioned by Clark, who reported 13 cases of cancer of the thyroid in children who had had irradiation to the head and neck, or neck and chest, for various reasons between 2 months to 6 years of age.

2. While incidence of lymphoid tissue recurrence in allergic individuals is high, recurrence is usually on the lateral walls of the nasopharynx and not high in the vault above the nasal septum. The vault is not in the pathway of postnasal drainage that occurs in these allergic individuals. This drainage is probably the most important factor in lymphoid tissue recurrence. Large adenoid regrowth in the vault is usually the result of active regrowth of incompletely removed adenoid tissue which, I am sure, was what happened in this case.

3. In the drum membranes of certain children who have conduction deafness there is so much thickening that it is difficult to determine the presence or absence of fluid. It is mandatory, then, that diagnostic myringotomies be done at the time of surgery to determine absence or presence of fluid which should be removed.

4. Fluid accumulation in the middle ears of these youngsters is painless, and in order to determine reaccumulation after incision and drainage, one must do hearing tests for at least monthly intervals until satisfied that the ears have stabilized.

Technical Considerations

Adenotonsillectomy is the most commonly performed surgical procedure. It is done by more different kinds of physicians than is any other operation and, according to statistics, ranks high in inefficiency. Many physicians are capable of performing good tonsillectomy, but most are just "in-and-outers" as far as adenoids are concerned. Old thinking that adenoid remnants will regress spontaneously, and therefore are not important, is outmoded. These tissues do not regress in the development years and can become a source of as much trouble as the original adenoid mass.

The pitfalls that lead to trouble and poor results in adenoid and tonsil surgery are:

1. Inadequate pre-operative history as to clear-cut indications and of bleeding.
2. Lack of close scrutiny of red blood count and hemoglobin.
3. Inadequate psychological preparation of the patient (and the parent).
4. Inadequate anesthesia.
5. Inadequate lighting.
6. Inadequate scrutiny of the effect of the mouth gag on teeth.
7. Dull instruments.
8. Inadequate exposure of nasopharynx and incomplete adenoid removal.
9. Improper and incomplete dissection of the tonsil and incomplete removal of the base that is adjacent to the tongue.
10. Inadequate hemostasis during the operation.
11. Failure to prevent blood from entering the larynx and trachea.
12. Lack of complete hemostasis in the tonsil fossae and nasopharynx before patient is returned to bed.
13. Inadequate observation by the nursing staff of the color, pulse, respirations and blood pressure. The most common error postoperatively is lack of recognition of signs of bleeding. These patients do not always spit out blood or bleed from the

nose. They may be swallowing blood that is oozing. This fact can be recognized only by careful scrutiny of color, pulse and blood pressure. (Postoperatively the patient should be kept on his side with head lower than shoulders.)

14. Reluctance to give blood transfusion at the early stage of trouble.

For surgery, I prefer ether insufflation anesthesia. The patient should be neither too light nor too deep. I object to endotracheal anesthesia for adenotonsillectomy in children. The endotracheal tube can traumatize the larynx and therefore may become an additional hazard. It is argued that the endotracheal tube prevents the tracheobronchial tree from being filled with blood. If the surgeon needs this kind of help, he should not be doing the surgery.

The throat is exposed with a fixed type of gag which is non-traumatic, that is, one which will not rest upon and possibly break the upper teeth. (Such a gag is the McIvor which rests upon the hard palate.)

I prefer to remove adenoids first to allow more time for nasopharyngeal hemostasis; curettes are sharpened before each case. A sharp adenotome, however, is not objectionable. In any event, after the main mass of adenoid tissue is removed, the nasopharynx is exposed by retracting the palate. For this, a specially designed palate retractor (Fig. 3) is used. This enables one to punch out the remaining adenoid tissue about the eustachian tube orifices, from the tori, if necessary, from the salpingopharyngeal folds, and the lateral pharyngeal bands. When this is accomplished, a large sponge with a string attached is applied to the nasopharynx.

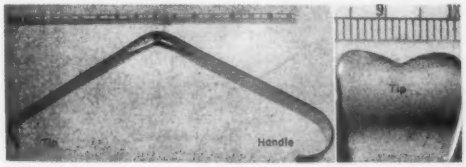

Fig. 3. Palate retractor.

The tonsils are removed by careful dissection, hugging the capsule closely. As much mucous membrane as possible is saved. If too much mucous membrane is sacrificed, the fossae will be flat and scarred. After the major portion of the tonsil is dissected out, it is removed with a snare. Following this a tag near the base of the tongue must be sought and removed. All bleeding is controlled with No. 1 plain catgut slip-knot ties. After both tonsils are removed, a sponge of one-half inch dental roll, to which a string has been attached, is placed into each fossa. The entire procedure is done working from above the head with the head lower than the shoulders. During the surgery the hypopharynx is constantly watched to make sure that no blood escapes into the larynx. If blood should by chance get into the larynx or trachea, it is removed with a catheter before the operation has been completed.

The nasopharynx is reinspected. If bleeding is still present, then the bleeding points are tied off with the same No. 1 plain catgut slip-knot ties. The patient is not removed from surgery until the nasopharynx and both tonsil fossae are completely dry, no matter how long it takes to accomplish this. The adenoid-tonsil operation should not be hurried. The best operation is not the speedy operation.

Otolaryngology residents at the Stanford Hospital look at me peculiarly when I tell them it takes about ten years to learn to do a good adenotonsillectomy. One has to follow one's cases from five to ten years to determine how efficient his surgery has been. It was such a follow-up on my own cases that caused me to improve my adenoidectomy technic. My present method has been satisfactory and gratifying, especially in the conduction-deafened children, of which there are many.

Summary

Some indications, contraindications, and pitfalls in adenotonsillectomy in children have been reviewed and suggestions in technic presented. In this discourse, I have touched upon two controversial subjects, (1) the use of irradiation in the therapy of infected, hypertrophied lymph tissue, and (2) the use of the endotracheal tube for anesthesia in this operation in children, and have expressed objections to both. In all fairness, there is another side, but reasons pro and con are so numerous that it would

not be possible to relate them in a brief presentation.

It is hoped that the plea for more meticulous technics and better results will gather momentum and that adenoid and tonsil surgery will be allowed to ascend to a plateau of respectability so long denied it.

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Corporations and the Practice Of Medicine*

William M. Sproul, M.D.

DES MOINES, IOWA

This experience in another region, especially in view of more recent newspaper publicity in the Rocky Mountain states, will be helpful in meeting our own corporate and hospital problems.

THE topic, "Corporations and the Practice of Medicine," is distressing and perhaps frustrating to physicians in the practice of medicine who are sincerely trying to provide their patients with the best medical care at reasonable cost. It seems that all our patients hear and read about the medical profession indicates first, the rapid advancements being made in the diagnosis and care of the sick and, second, that something is wrong within the profession, because of the public airing some charges of fee-splitting, unnecessary surgery, incompetence, greed, etc. All this can be summed up by saying that the public is being fed largely on sensationalism. The story of that side of our profession which tries to help the patient spread the costs of illness, or tries to protect him from the costly interjection of a third or administrative party between him and his physician, is called dull reading, and does not deserve front page space or glaring headlines. In Iowa, we are told that our papers will be glad to print the latter kind of material—if we will pay for the space. So when the threat of commercialism in medicine raised its Medusa-like head in Iowa and the doctors decided to deal with it, we were painted very black. But, our collective conscience is clear and we have won a decisive first step, although we realize there is more to come.

Perhaps it would be well for us to examine at the beginning why we should be interested in the organizations that sponsor medical care plans which provide payment for physician's care in a hospital, home, office or clinic. For details on this subject, I will refer you to the Journal of the A.M.A., December 3, 1955, page 1370—"The Progress Report of the Commission on Medical Care Plans."

In the first place, this report does not

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even mention care provided by the Veterans Administration. But it does consider:

1. Medical Society and related plans including Blue Shield.
2. Private insurance programs.
3. Student health services.
4. Industry programs providing non-occupational medical care.
5. Occupational disability programs, i.e., workmen's compensation, and
6. Miscellaneous and unclassified plans.

This last grouping is the one I expect to consider here, as it includes union-sponsored health plans and closed panel plans best exemplified by the Kaiser-Permanente plan and its various offshoots and ramifications. The only figures I am going to bore you with relate to these two plans just mentioned. The exact number of the miscellaneous or unclassified plans is thought to be in the neighborhood of 300. Seventeen and one-half per cent of these are union-sponsored and cover the greatest enrollment (or 36 per cent). Seven per cent are closed-panel plans and enroll about 1.4 million persons, which constitutes 28 per cent of the total number enrolled. This 7 per cent is made up of corporations in the practice of medicine, or shall we name the situation, the commercial practice of medicine, as opposed to government practice and private practice.

It is common knowledge that union-sponsored or closed-panel plans are growing at an alarmingly rapid rate in the United States. A new angle on the closed-panel plan is the nebulous ideology based on the theory that the hospital should be the health-center of the community and, as such, it should be permitted to employ physicians to provide all services pertaining to the physical well-being of all persons in its vicinity or territory. The hospital could then fit itself with a professional staff, refuse to allot beds to other physicians in the community—except perhaps as its beds were empty—and dictate the actions and accomplishments of its closed-panel staff. It would purvey the services of its physicians for its own profit without question. This is what the physician-hospital controversy in Iowa was about basically. Fortunately for Iowa residents, our bulwarks were in our laws regulating the licensing of hospitals and in our medical practice act. It was against these laws that the Iowa Hospital Association leveled its attack.

It seems paradoxical to consider the hospitals making such a move. Obviously, should they be successful in legalizing the employment of physicians by corporations (either profit or non-profit), the door would then be opened for group cooperatives of all types, shapes and forms to enter Iowa and take away business, not only from the doctors, but from the hospitals themselves. It is well known that Kaiser-Permanente has hurt the hospitals on the west coast the same as it has encroached upon the private practice of medicine; so really, the hospitals are helping to sign their own death warrant by fighting the medical profession. It is difficult to believe this is what they wish for.

The socio-economic reasons behind the change in thinking on the part of the hospitals are many and more or less speculative. Perhaps in the future the cold eyes of history may be able to point a steady finger at a simple underlying principle as the cause for such a sudden change. The official statements of the attitude of the American Hospital Association toward the physicians of our country and their mutual relationships as late as 1954 gave no hint of so great an impending reversal as has been evidenced all over the country since then (Colorado, Ohio, Iowa, et al.).

We hear the statement that "such is progress." We think of progress as a movement forward or as gradual betterment—that is, development or evolution of mankind as a process. Therefore, socio-economic progress would be evolution toward better living conditions sociologically and economically. In our society, physicians have been striving to improve the quality of medical care and relate this improvement to the existing economic situation. We have set up the most successful plan for prepayment medical care in the world in our own Blue Shield. Nowhere in the world did a plan exist for such widespread dissemination of new medical knowledge until the American Academy of General Practice came into being in 1947. Since everything we get must be paid for sometime by someone it is difficult, if not

impossible, to see what the American people want of us. Our scientific knowledge and our prepayment plans may and will undergo perfecting tendencies. So yes, we must hope for socio-economic progress, too, in medical care, but what price do the American people want to pay for it? I am not referring to dollars and cents. And is the practice of medicine by any corporation the answer? When a person is sick, who is going to get him well—the doctor, or the doctor's employer? Would a hospital, as an employer, be any different than any other employer whose eyes must be focused constantly on a set of books? These are disturbing thoughts.

I have been informed that there have been several instances here in your state where anesthetists have been refused the privilege of staff appointment simply because they would not agree to work, under contract, for the hospital. Anesthetists were involved in the origin of our Iowa case with the hospitals. It all dates back to 1949 when the Blue Cross Comprehensive 70 contract was originated as an outgrowth of labor-management negotiations between U. S. Steel and National Blue Cross-Blue Shield officials. This Comprehensive 70 plan, as offered to certain national industries in Iowa, is patterned after the National Comprehensive 70 plan and provides paid-in-full benefits to patients in semi-private rooms in participating hospitals. This includes full payment for medical services such as x-ray, pathology and anesthesia when provided by an employee of the hospital and billed by the hospital. This is discriminatory and results in loss of benefits when a Blue Cross member utilizes the services of a doctor who does not accede to being classified as a hospital employee.

During the years 1949-51, the AMA Committee on Hospitals and the Practice of Medicine (known as the Hess Committee) was active and as a result on December 7, 1951, the House of Delegates approved what is known as "Relations of Physicians and Hospitals (Guides for Conduct of Physicians in Relationships with Institutions)." This has been popularly known as the Hess Report and quoted the Principles of Medical Ethics of the AMA, Chapter III, Article VI, Sec. 6 on Purveyal of Medical Service.

In April, 1952, the Iowa State Medical Society requested Blue Shield to investigate the possibility of extending its benefits to cover all medical services, including x-ray, pathology and anesthesiology, thus relieving Blue Cross of this responsibility. Then in September, 1952, the medical society reaffirmed that the services in question should be rendered only under the direct supervision of licensed doctors of medicine, and directed that the attention of Blue Cross-Blue Shield officials be called to the logic as well as the legal reasons for changing this coverage from Blue Cross to Blue Shield. Our law on licensing of hospitals restricts hospitals to provide bed and board, general nursing care, use of operating and delivery rooms, ordinary medications and dressings, and other customary and routine care. In December, 1953, the House of Delegates of the AMA condemned all insurance contracts which classify any medical service as a hospital service. So, on January 7, 1954, the state medical society recognized the local situation again and declared it was "essential that hospitals and physicians should recognize the confines of their practice" and appointed a special committee which was to meet with Blue Cross and Blue Shield officials with the objective of eliminating "the practice of medicine by hospitals and placing it in the hands of those legally qualified to practice medicine." The committee was further instructed to provide for transfer of these medical services from Blue Cross to Blue Shield in an orderly and fair manner so that no subscriber would suffer any loss. The directive called for positive and immediate action, lacking which, the medical society would support legal action challenging the right of hospitals or corporations to practice medicine.

In February of 1954, the Iowa Attorney General was requested by the Iowa Board of Medical Examiners to issue an opinion clarifying the law with respect to physician-hospital relations. This was deemed especially important by the Board, to ascertain whether the Iowa Medical Practice Act applied to radiologists and pathologists. This opinion was issued on February 19, 1954, and clearly stated that radiology and path-

ology are integral parts of the practice of medicine.

Iowa laws are explicit in stating that a corporation cannot practice a profession, i.e., medicine, dentistry or law. Although most hospitals are non-profit corporations, they are still corporations in the terms of the law. Moreover, if the law were to permit hospitals to practice radiology or pathology, any less benevolent corporation, or even an unlicensed individual might come into Iowa, employ physicians, even general practitioners, and go into the business of practicing medicine.

In addition to the fact that we, as physicians, must work under a medical practice law, we must also abide by the tenets of the code of ethics of the American Medical Association (Principles of Medical Ethics, AMA 1943, Chapter III, Art. VI, Sec. 6). This code of ethics is violated when a physician "disposes of his professional services to any hospital, lay body, organization, group or individual under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned." Thus, the physician violates the code of ethics and the hospital violates the Iowa law when the doctor permits a hospital to bill in its own name for his services. This is secret division of fees.

In 1954, the fancy "footwork" on the part of the Iowa Hospital Association began. Our committee and a special committee from the hospital association got together and ultimately held several conferences with the Attorney General. A contract that would be mutually satisfactory came close to fruition on several occasions, but the hospital association continually pressed for further advantage or at times engaged in sheer obstruction tactics. The Attorney General invited both parties to submit suggested contracts which the individual side felt met the requirements of both law and ethics and which could be applied on the local level. The Attorney General then drafted therefrom a compromise agreement. This was approved by the medical society, but was rejected by the hospital association. At a meeting of the two committees to discuss this compromise settlement, all but three of seventeen basic points were agreed to. Immediately thereafter, the hospital association notified the Attorney General that it was withdrawing all the sample contracts it had submitted and that it disapproved of his proposed compromise.

We believe the purpose of the hospitals in this move was based on their belief that part of the work done in the pathology and radiology laboratories does not constitute the practice of medicine. They have maintained that only those procedures performed by the physician himself should be considered medical practice, and all other procedures which he supervises, directs, or interprets should be regarded as hospital service and billed as such. Of course, the medical society has maintained that all of radiology and pathology services contribute to the diagnosis and treatment of illness and that every facet of this work constitutes the practice of medicine, as confirmed by our Attorney General. The hospitals felt that radiologists and pathologists should not be permitted to bill for their services rendered to hospitalized patients.

Our medical society believes that patients must be billed in a manner which will inform them that they are paying for the services of physicians, and that any other approach amounts to secret division of fees. It was on these two points that we were unable to reach agreement on the compromise proposal of the Iowa Attorney General with the hospital association. On November 8, 1954, in a supplemental opinion, the Attorney General made suggestions in his efforts to enable the doctors and the hospitals to resolve our differences. We felt that this supplemental report incorporated means for settlement which were fair to hospitals, protected especially the interests of the patient, and permitted doctors to practice medicine in compliance with the law and the established code of ethics. At this juncture, it was our belief that individual physicians and individual hospitals should cooperate to develop legal and ethical contracts on the local level as provided in the Attorney General's supplemental opinion. This the hospitals refused to do.

The contestants were called to appear before a joint committee of the AMA and American Hospital Association in Chicago

in 1954. Representatives of the Iowa State Medical Society were asked by Dr. Walter Martin, then President of the AMA, if they would agree to a thirty-day truce or cooling-off period and our group readily acquiesced. When the representatives of the Iowa Hospital Association were asked the same question, they voted unanimously against it. So the joint committee took the statements of the two contestants under advisement and was to issue its recommendations for settlement at a later date. These recommendations never appeared.

Early in 1955, a suit for declaratory judgment was filed by thirty-four Iowa hospitals representing the Iowa Hospital Association against the Iowa State Board of Medical Examiners, the Iowa Association of Pathologists and the Attorney General. The Iowa State Medical Association entered the suit as an intervenor.

The trial began on May 19, 1955, and recessed on June 28; resumed September 15 and ended October 25, a total of thirteen actual weeks. It is of interest to you to note that Mr. MacCahal, the talented and highly efficient Executive Secretary of the American Academy, has written a scholarly and exhaustive thesis on the topic, "Employment of Physicians by Hospitals: Some Legal Aspects." A copy of this thesis was of great help to the physicians' attorneys in preparing the defense in our case.

When the trial was resumed in September, the hospitals offered a means of settlement in the form of a Consent Decree. This was done in a very sub rosa and indirect fashion. Their attorneys did not openly approach our counsel, but by a devious path reached the president of our state society, who immediately laid it before our legal counsel. A little study soon showed it to be just another offer to settle by our complete capitulation of both law and medical ethics. We rejected their proposal but we did not reveal the actions of the hospitals to the judge trying the case. (There was some question concerning the legal ethics in the presentation of such a decree to our side in the manner followed, especially without the knowledge of the trial judge.) Both sides presented twenty-four or twenty-five witnesses. Many were local men, but many were brought in from various parts of the country for the contributions they could make to our cause.

The judge's decree was filed late in November. For the sake of brevity, this long trial and equally long decree can be summarized easily in five questions the court was called upon to decide, and the hub of the court's answer to each of these questions is as follows:

1. Are pathologists, radiologists and technicians engaged in the practice of medicine?

Answer: "The work done by the pathologists, radiologists and the technicians working in the pathology and x-ray laboratories, constitutes the practice of medicine."

2. Who may legally practice medicine in Iowa?

Answer: "Under the Iowa law, the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation."

3. May non-profit corporations, and boards operating public hospitals, practice medicine in Iowa?

Answer: "Plaintiff hospitals are not excluded from the requirements of the Iowa practice acts in regard to the practice of medicine on the basis that they are non-profit corporations."

4. Does public policy require that the operation of pathology and x-ray laboratories by hospitals be continued?

Answer: "Plaintiff hospitals are not excluded from the requirements of the Iowa practice acts in regard to the practice of medicine—because of long-standing custom and inactivity on the part of those charged with enforcing the law, or because of public policy in the absence of legislative enactment."

5. Is it unprofessional conduct, as defined in the Iowa Code, for a pathologist or radiologist to permit a hospital to bill for the physician's services in the name of the hospital?

Answer: "The pathologists or radiologists, by permitting the hospital to bill for medical services in the name of the hospital without the consent of the patient or his legal representative, violate the provisions of the Iowa Code pertaining to unprofessional conduct."

Without a shadow of a doubt, this was a complete victory for the doctors of Iowa. But this is only the first "plateau." The Iowa Hospital Association has appealed the decision to the Supreme Court of Iowa, telling us that this is being done to prevent any enforcement of the District Court decree until they can get to the legislature and make a Herculean attempt to change our Medical Practice Act. So, we still have a physician-hospital controversy in Iowa. It is unlikely that we will have an opinion from our Supreme Court until the end of this year, at the very earliest. We do not expect much trouble there. But, who knows what a legislature will do? So that will be a big and an expensive job. We doctors paid for our defense from our own pockets. The hospitals charged their members one cent per bed per day, so their "patients" paid their bill for them.

The latest development is a letter from the hospital association to Iowa doctors asking us to accept the terms of the proposed Consent Decree of last September, openly flouting Iowa's law, but pouring over the thing a syrupy bait in the form of some suggested action prohibiting employment of clinicians. This did not work.

It has been a pleasure to record our Iowa troubles. We sincerely hope you will find, in our remarks, some assistance to help you keep out of trouble here in Utah, the other Rocky Mountain states, and the Northwest. It can be done with your courage and steadfast conviction. Iowa has set a precedent for you. We have made a court record which will help protect you, especially if you are diligent.

Hemangioma of The Liver

Kenneth C. Sawyer, M.D.
Robert E. McCurdy, M.D.
Alexis E. Lubchenco, M.D.
DENVER

IN 1954, one of us (KCS) reported fifteen cases in which a substantial portion of the liver was resected. The procedure was performed four times for primary benign tumors of the liver, five times for secondary malignant tumors of the liver. On six occasions, the left lobe was excised to find a bile duct in persons with hepatic portal obstruction. Two of the primary benign tumors were hemangiomas.

Small hemangiomas of the liver are seen occasionally during postmortem examinations and at times during laparotomy. Schumaker has said that such tumors rarely grow large enough to cause symptoms or signs which lead to operative treatment. In the two liver hemangiomas previously reported by us, one tumor was removed because we thought it might be a metastasis from a pelvic neoplasm; the other was excised because it had been inadvertently ruptured during the removal of a diseased gallbladder, and the bleeding could be controlled only by excision of the entire tumor.

Because of the increased interest in liver surgery and to illustrate the feasibility of removing almost the entire right lobe of the liver, we are reporting an additional case of large hemangioma of the liver.

CASE REPORT

Miss L. N., white, aged 57, was admitted to the hospital on June 2, 1956, because of a large mass in the abdomen. She complained of burning in the epigastrium, indigestion, and an increase in the size of her abdomen. Two months previously, a physician had discovered the mass and advised its removal. There was no history of weight loss, and a review of the systems was not revealing.

General examination revealed nothing significant except a firm, round mass below the xiphoid which descended with respiration. There was also an ill-defined, irregular mass in the right flank. Examination of the blood was negative. The urine examination was essentially normal. Gastrointestinal roentgenograms revealed an enlarged duodenal loop and a pressure deformity within the loop on the duodenal bulb in the first portion of the

duodenum. The duodenum was pushed upward and to the left. We decided that we were dealing with a malignancy of the head of the pancreas with metastasis to the liver.

With the patient under pentothal cyclopropane anesthesia, a long transverse incision was made. The stomach was pushed to the left side by a large, irregular mass, which occupied al-

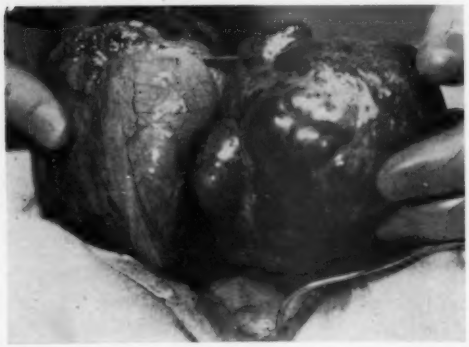

Fig. 1. Photograph of tumor taken at operating table, showing the extent of the tumor before excision.

most the entire lobe of the liver (Fig. 1). Further study of the liver revealed the tumor to be clearly demarcated. Because of our previous experience with hemangioma of the liver, we thought it unwise to take a specimen for biopsy.

The peritoneal attachments of the right lobe of the liver were divided; the liver was lifted out of the abdomen; and almost the entire right lobe, together with the gallbladder and the caudate lobe, was removed without difficulty. Removal was begun by ligating and dividing the cystic artery and the cystic duct. Deep mattress sutures were placed through the entire thickness of the middle fourth of the right lobe of the liver. The right hepatic artery and the right hepatic duct were visualized at the portal of the liver. The liver was divided just distal to the mattress sutures and the hepatic

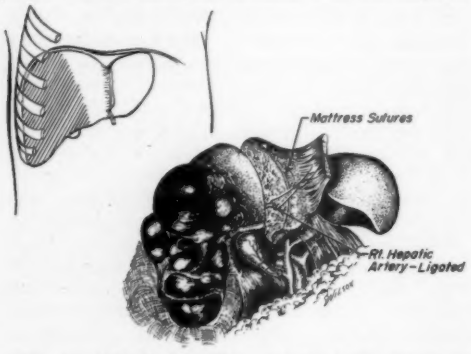

Fig. 2. Artist's drawing showing the extent of resection. The cystic duct and the cystic artery are divided and ligated. The right hepatic duct is ligated within the substance of the liver tissue.

artery ligated within the substance of the liver so as to preserve circulation to the remaining portion of the right lobe (Fig. 2). Several individual vessels and ducts were clamped, divided, and ligated as they were encountered in the liver substance.

No attempt was made to close the raw surface of the liver. It was covered with a large piece of Gelfoam, and the omentum was placed up against it. Four Penrose drains were placed beneath the right side of the diaphragm and along the right peritoneal gutter. One was brought out through the incision and three through a stab wound deep in the right flank.

The pathologist's report was as follows: The specimen was a portion of liver weighing 600 gm. and measuring 20 by 11 by 4 cm. It was extremely nodular and was bluish over almost its entirety. A small amount of yellow-gray tissue to one side resembled liver capsule. Attached to the under surface was a 3.5 by 11.5 cm. thin walled, friable gallbladder, which contained approximately 10 cc. of thick, golden-brown bile (Fig. 3). The mucosa was dark

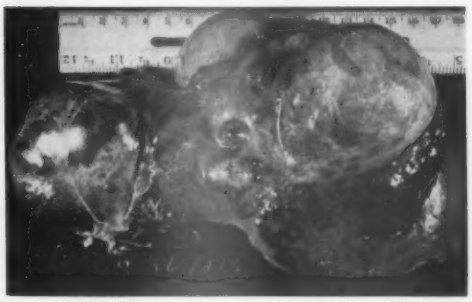

Fig. 3. Gross specimen of the excised lobe of the liver with the gallbladder attached.

brown with prominent trabecular markings. Upon sectioning, almost the entire specimen was displaced by a large, spongy, dark, blue-black lesion, which appeared encapsulated around almost its entirety and from which a large amount

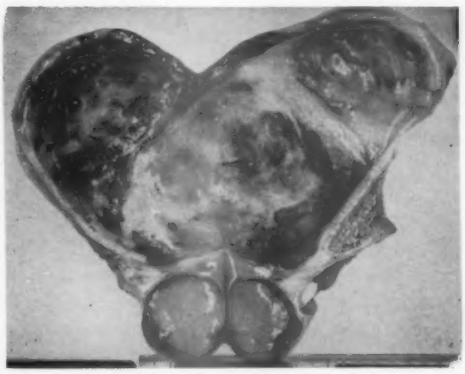

Fig. 4. Cut surface of the gross specimen.

of blood poured. In one area of 4 cm., which apparently was separately encapsulated, there was some shiny, white, spongy tissue. There was a small amount of normal appearing liver parenchyma around one edge of the specimen (Fig. 4).

Upon sectioning, some calcification was found within the whitish area. Sections of the liver presented large, irregular, various sized, endothelial lined spaces, most of which were filled with red cells. These spaces were surrounded by dense, fibrous trabeculae. The attached liver had congested sinusoids, and the periportal areas

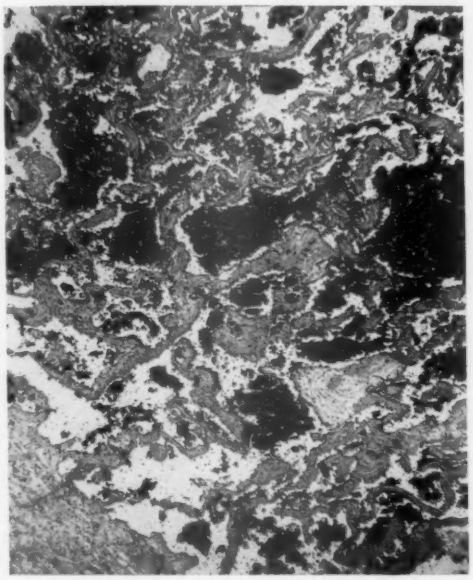

Fig. 5. Microscopic section of the tumor demonstrating a cavernous hemangioma.

were lightly infiltrated with lymphocytes (Fig. 5). The final diagonsis was cavernous hemangioma of the liver.

The patient left the hospital on the fifteenth postoperative day.

Comment

Large portions of the liver are being resected more and more frequently. Resection of the right lobe of the liver, however, is rather infrequently performed. Total lobectomy is usually confined to the left lobe. Wangensteen successfully removed a right hepatic lobe, which had been completely replaced by metastatic gastric cancer; and the excision of large sections of the right lobe has been reported by Quattlebaum, Pack, Brunschwig, Stone, Saypol, Turner, Wendel, Wright, and others.

Hemangioma is said to be the most common resectable tumor. It occurs more frequently in the liver than in other organs of the body. These vascular tumors are often difficult to remove. Wilson and Tyson have reviewed the literature for the incidence of hemangioma of the liver. They collected eighty-four cases of hemangioma of the liver in which the patient had been operated on. The tumor was resected in seventy-one of these cases. We added two cases in 1954 and are here adding another.

D'Errico has emphasized the seriousness of spontaneous or accidental rupture of these lesions. He found fourteen patients in whom rupture occurred, and all but two of them died. Mantle has reported a death from hemorrhage resulting from aspiration of a hemangioma of the liver with a fine needle during laparotomy. Taking a specimen of hemangioma for biopsy may present a difficult problem in controlling hemorrhage. It is generally agreed, however, and our experience bears it out, that, regardless of size, these specimens may be removed surgically if the resection is carried out through normal liver tissue rather than through the vascular tumor.

Despite reports of success, surgeons have always considered the removal of segments of the liver a formidable procedure. They have been concerned over the amount of liver that could be safely removed without seriously disturbing its function and over their ability to control hemorrhage adequately. Fishback and others have shown experimentally that four-fifths of the liver of animals may be removed safely. The regenerative capacity of the liver partially destroyed by disease processes and trauma has been demonstrated many times. The right and left branches of the hepatic artery anastomose freely so that if either main branch is divided during the resection, the intact branch can adequately supply the remaining portions of the liver. We preserved the right hepatic artery in our patient until it was encountered while transecting the liver so as not to jeopardize the circulation to the remainder.

Duckett and Montgomery have pointed out that any part of the liver could be re-

moved without jeopardizing the nutrition of the remainder. Cameron and Mann have emphasized that one must not damage the main hepatic artery. Death always follows ligation of the hepatic branch of the hepatic artery at its entrance into the liver, Mann and his co-workers have reported, although ligation at the point of origin is without effect. If the hepatic artery is compressed for more than ten minutes, Shallow and Wagner have said, blood pressure falls greatly.

We elected to ligate the hepatic artery in the liver substance to preserve circulation to the remaining portion of the liver.

Summary

Another case of large hemangioma of the liver is added to the literature to re-emphasize the practicability of resecting a large portion of the right lobe of the liver. It has been demonstrated that large amounts of liver tissue can be removed without seriously disturbing the function of this organ provided circulation to the remaining tissue is preserved. Ligation of the hepatic artery in the liver substance is suggested as a means of preserving this circulation. Spontaneous or accidental rupture of a hemangioma of the liver frequently results in death. Regardless of size, however, these vascular tumors can be excised without difficulty if the excision is carried out through normal liver tissues rather than through the tumor itself.

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Audible Heart Tones During Surgery*

Paul Dudley Keller, M.D.
SALT LAKE CITY

FOR a long time it has seemed to me that it would be desirable for the anesthesiologist, the surgeon and his assistants to be able to hear the heart beat continuously during each operation. It is felt that the knowledge as to rate, rhythm and force of the heart, if constantly available, would be helpful to "the team" in evaluating the status of the patient as the operation proceeds.

Critical situations arise daily in the operating room when the surgeon and his anesthesiologist must decide whether to stop an operation or whether to proceed, and whether to give blood or to administer drugs. The surgeon sometimes must decide whether to do the initial stage of a surgical procedure, or whether to do a definitive operation. Sometimes while doing cancer surgery, he must decide whether a palliative procedure is the best selection, or whether, against large odds, he should try for a cure. The more information he has available about the patient, the more logical the decision he can make. It is believed that a running, first-hand knowledge of the heart beat will often be helpful in making such decisions. One can ascertain the effect on the heart beat that results from the manipulation of vis-

*From the Surgical Service of the Memorial Medical Center, Salt Lake City, Utah.

cera and the effect of other technical steps as an operation proceeds. I think that if these effects are learned as he is trained, the young surgeon will be better conditioned to handle tissues gently.

It is true that the anesthesiologist can auscultate the heart with the conventional stethoscope periodically and relay the information on to the rest of "the team," and most of them do. There are periods during each anesthetic, however, when other details in the administration of the anesthetic require the anesthesiologist's attention so that continuous auscultation is impossible. There is a real advantage to all concerned in hearing the heart beat constantly and without the encumbrance of ear phones.

When the sounds of the heart beat are constantly available there can be no excuse for a catastrophic delay in diagnosis of cardiac standstill, as has been so frequently the case in the past. With the steady increase in medical reports of the incidence of death or disaster from cardiac standstill in surgeries throughout the world, and with the high incidence in my own hospital, the need for suitable equipment to broadcast the heart beat during surgery has become magnified. It is suspected that as experience is gained in utilizing this principle, that changes in cardiac rhythm will be found to precede cardiac arrest and that they can be recognized in time to anticipate and prevent the cardiac standstill.

There has been a lot of research and advances have been made in the field of cardiac phonodynamics during the past ten years. Much study relating to the field of cardiac dynamics is being undertaken at several medical centers at the present time. A great many authors have contributed to the understanding of the heart sounds and of heart murmurs by evaluating them with the use of the electronic stethophone, the phonocardiograph, the spectral phonograph and by the electrostethograph. Valuable technics and instruments have been developed. The idea of broadcasting heart sounds in a room by loudspeaker or via earphones has been utilized to some extent in the teaching of auscultation to medical students. However, the broad field of application, I feel, lies in the operating room during surgery.

Experimentation

For the past four months I have successfully reproduced the heart sounds through a loudspeaker on over 500 different human subjects of assorted ages, sizes and builds while routine physical examinations were being done. All patients have been examined in sitting and prone positions. As one would suspect by experience from auscultation of the heart with a stethoscope, heart sounds are more easily heard and broadcast best while the patient is in a sitting position. At the Memorial Medical Center we have also broadcast the heart sounds on the majority of patients undergoing surgery with local and general anesthetics. The broadcast of heart tones with the equipment originally available was unsatisfactory in the thick-walled, obese, emphysematous chest when the patient was lying down. With the equipment we are currently using, "cardiocasting" is possible on all patients.

Of course, the principle advocated above cannot be applied for surgery of the chest—here it is not necessary as the heart can be seen and palpated during surgery—nor in surgery of the left chest wall. When surgery of the upper abdomen is done, amplified sounds from contact of instruments against the chest are objectionable, but this can be minimized by judicious placement of the 'cardiocaster" head and by keeping the amplifier tuned low.

Some of the more temperamental surgeons may object to the idea of audible heart sounds during surgery on the ground that it will distract their attention and make concentration difficult. In this case, the amplifier can be turned down so that only the anesthesiologist can hear them, and the objection is overcome. From these preliminary studies, it is believed that the young men who are conditioned as they are trained in surgery will find application of this principle a great adjunct to safer surgery. They will readily learn to notice abnormal heart and respiratory sounds just as they have become conditioned to notice abnormalities in color of blood, in the color of tissues and in audible respiratory sounds as well as

other visible, palpable and audible physiopathological phenomena.

Discussion

There are certain technicalities that make the broadcasting of heart sounds difficult. The main one is the need for such a wide range of amplification. The heart sounds of a thin, vigorous child who is sitting are loud and need little amplification so that the tones can easily be heard via loudspeaker. In contrast, the heart tones of an obese, emphysematous, hypotensive patient, who is lying on his back on an operating-room table, require much amplification in order to be heard. In the obese, asthmatic patient, other chest and chestwall sounds are sometimes as loud as the heart sounds themselves and they tend to drown the heart sounds out. This is overcome by judicious placement of the "cardiocaster" head and by frequency selection of the tones to be emphasized. Another technical difficulty lies in the fact that when high amplification is accomplished the "feed back" will drown out the heart sounds and cause much distraction. However, through experimentation, these difficulties have been overcome and with the equipment we are currently using, the heart sounds can be nicely broadcast in all subjects. Accurate reproduction of the heart sounds is not important for this proposed use because rate, rhythm and force are the essentials, whereas when murmurs and normal heart tones are studied, accurate and faithful reproduction is essential.

Simultaneous broadcasting of the respiratory sounds so that the rate, depth and rhythm can be heard is possible. However, care must be used in placement of the "heart beat pickup" so that respiratory sounds are not too prominent. We are still experimenting to find the ideal apparatus for applying the above advccated principle, and a report is forthcoming.

Summary and Conclusions

1. The concept is advocated that the heart sounds of patients should be continuously audible to the anesthesiologist and the surgical team via loudspeaker while they are undergoing surgery. Certain limitations are discussed briefly.

2. It has been learned from experience at the Memorial Medical Center that the broadcasting of heart tones during surgery is feasible. Details on the cost, construction and application of the ideal equipment for this purpose, after further experience with different methods of amplification and broadcasting is obtained, will be published.

3. It is believed that the "cardiocaster" will prove a real adjunct to surgery and will help solve the problem of cardiac arrest.

*Smears and Sections on Study of Aspirated Marrow**

Matthew Block, M.D.
DENVER

I. Introduction

Examination of smears of aspirated bone marrow has become a common procedure in clinical medicine as evidenced by the fact that many hematologists have each examined thousands of specimens. Nevertheless, only rarely[1,2,3,4] has any study been made of the accuracy and validity of the technic.

The adoption of dry smears as the technic of choice for the study of aspirated marrow is based more upon chance than a reasoned approach to the problem of accurate reproduction of the number and distribution of marrow cells. The science of clinical hematology largely dates from the first use of the Romanowsky stains (Wright and Giemsa stains are examples) to render hematopoietic cells recognizable under the microscope. Relying primarily upon the study of Romanowsky stained smears of the peripheral blood, the first hematologists became

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remarkably proficient in the differential diagnosis of diseases of the hematopoietic tissues. They, as well as contemporary hematologists, were impressed by the clarity of cytologic detail in smears, and by contrast, the loss of cytologic detail in sections of hematopoietic tissue prepared by routine histopathologic technics. Consequently, when a comparatively simple technic of bone marrow aspiration was discovered, it was not surprising that the hematologist should use a staining technic with which he was familiar and which yielded the best cytologic detail, even if prior experience with that technic had been limited to study of peripheral blood cells. No attempt was made to assay any other method of studying marrow aspirates.

II. Structure of the Marrow

Review of marrow histology[5] may help explain the discrepancies between the distribution of cells found in smears and in the marrow itself. The marrow is composed of a scaffolding, the reticular cells and fibers, which supports the hematopoietic cells and blood vessels. The reticular cells form a network around which the fibers are entwined so that each cell is encased in its own network of fibers much as a foot in a stocking.

The free cells are suspended in this network; some, especially the circulating erythrocytes, float freely in sinusoids; others, the erythroblasts, are found in dense clumps with the most immature cells at the center of each clump. Granulocyte precursors are scattered singly or in loose groups. Megakaryocytes are usually scattered singly. Plasma cells are usually in rows along the arterial capillary walls[6,7]. In addition, in various diseases, the marrow may contain carcinoma cells, granulomas of tuberculosis and related diseases, excess iron deposits and infectious organisms, all of which are located in some specific marrow structure.

III. Analysis of Distribution of Cells in Marrow Smears

Several difficulties arise when one attempts to evaluate the number and distribution of the constituents of the marrow in its normal intramedullary location based upon what is seen in smears of aspirated marrow.

An inadequate specimen may have been obtained if the end of the needle was not in the marrow, or if the marrow was very hypercellular or hypocellular. Occasionally the field is obscured by masses of red cells or the marrow clumps may be so thick as to prevent study. However, these technical difficulties may usually be resolved by proper attention to the preparation of the smears.

Assuming aspiration of an adequate specimen and proper preparation of the smears, there are other problems which cannot be resolved because of factors inherent in the morphology of the marrow itself. First, aspiration itself has some selective effect upon which marrow structures are sucked out. Red cells floating freely in the sinusoidal blood are naturally aspirated more easily than fixed reticular cells. Unfortunately, this contamination by sinusoidal blood is variable from one aspiration to another.

Second, when the smear is made, regardless of whether fluid marrow or marrow particles are used, or whether the smear is made by cover glass or slide, marrow particles shed cells. These cells are moved along the slide in part in accordance with their degree of attachment to the marrow particle and also in ratio to poorly defined, but none the less real, physical factors of adhesiveness to the slide. For example, megakaryocytes move out further than other cells.

In addition, no matter how carefully the marrow particles are smeared, there are always areas where the cells are present in overlapping layers that are useless for study. Occasionally areas are found where the cells are one or two layers in thickness. Usually, one is forced to examine cells shed or deposited at the periphery of marrow particles. The distribution of these cells, forming a corona around the marrow particle, will vary just as much with the physical factors governing their attachment to the marrow scaffolding and their movement along the slide away from the particle as with their number in the marrow.

IV. Material and Technic

During the course of the last seven years, based upon an analysis of approximately 4,000 marrow aspirations, these theoretical considerations have been tested by comparing smears and corresponding sections of aspirated marrow. Smears were prepared from fluid marrow and marrow particles. Sections were prepared by the Maximow method (Zenker-formol fixation, sectioning in nitrocellulose, hematoxyln eosin-azure II staining). This somewhat unusual method was adopted since it delineates fine cytology as well as smears stained by Wright's or Giema Stains[4]. Smears and sections were examined as unknowns.

V. Results

1. Cellularity of the marrow.

The degree of hyperplasia or of hypoplasia of the marrow is often of diagnostic importance. As a general rule the smears were less cellular than the corresponding sections. The more cellular the marrow, the greater was the error. For example, in more than half of the cases of polycythemia vera the smears were acellular whereas corresponding sections were hypercellular. If the marrow was fibrous it was usually impossible to aspirate material for sections or smears. Therefore one cannot emphasize too strongly that an acellular smear has no diagnostic significance and should never be accepted as evidence of marrow acellularity. Similar conclusions regarding the unreliability of smears and hematocrits in estimating cellularity have been reached by Berman[8].

Since abnormalities in cellularity cannot be detected accurately by examination of smears, one would expect difficulty in analyzing minute changes such as those due to nitrogen mustard or radiophosphorus.

For example, Wasserman[9] was unable to demonstrate any effect of therapeutic doses of radio-phosphorus upon the cellularity of smears of bone marrow of patients with polycythemia vera; in sections a decrease in celluliarity was seen under similar circumstances[10,11]. In leukemia successive attempts at marrow aspiration result in progressively more acellular smears, in part due to increasing fibrosis, whereas the marrow, as shown by sections, remains solidly cellular. This had led to the misleading concept of "unpacking the marrow" by specific therapy and so to injudicious treatment.

In addition to recognition of atrophy, only in sections will one be able to discriminate between simple atrophy and serous fat atrophy. Serous fat atrophy may occur in inanition, protein deprivation, hypothyroidism, debilitating disease and following various cytocidal therapies. It is of much graver prognostic significance than simple atrophy and is almost always a contraindication to initiation of systemic cytocidal therapy as urethane, nitrogen mustard, and radio-phosphorus.

2. Number of megakaryocytes and platelets.

A relatively accurate estimate of the number of megakaryocytes is of major significance in the differential diagnosis of thrombocytopenic purpura. The diagnosis of idiopathic thrombocytopenic purpura should not be made in the complete absence of megakaryocytes. Cases have been encountered where no megakaryocytes were demonstrable in smears, but were seen in sections. In the early stages of chronic myelogenous leukemia, polycythemia vera and myeloid metaplasia, increased numbers of megakaryocytes are seen in sections, a finding of diagnostic and prognostic value. In smears, the number of megakaryocytes is difficult to estimate accurately[1,2].

Platelets were not seen in sections. However, a fairly accurate estimation of the platelet count could be made by examination of smears.

3. Myeloid: erythroid ratio.

Practically all atlases of hematology agree that the normal myeloid: erythroid ratio in smears is 2:1 to 3:1. In marrow obtained from twelve normal volunteers the myeloid: erythroid ratio in smears was similar to that quoted by most authorities.* In the corresponding sections the ratio was 1:1. Similarly in all the approximately 4,000 as-

*The author would like to thank Dr. Ernest Beutler and Dr. Raymond Dern for the use of this material.

pirates studied there was consistently a higher myeloid: erythroid ratio than in the corresponding sections.

This ratio has special significance in the differential diagnosis of chronic myelogenous leukemia and leukmoid reactions, especially polycythemia vera. In sections more accurate estimation of the cellularity, degree of iron storage, and myeloid: erythroid ratio made the differential diagnosis between chronic myelogenous leukemia and leukemoid reactions less subject to error.

4. Plasma cells.

Reference to atlases of bone marrow cytology will demonstrate how little agreement there is concerning the normal number of plasma cells in human marrow. The major reason is that most plasma cells are located in the walls of arterial capillaries[6,7] and only when this wall is ruptured do the cells spill out onto the smear in recognizable form. Estimation of the number of plasma cells in sections resulted in a better correlation with the patient's plasma globulin level. Since hyperglobulinemia is an accompaniment of many chronic diseases, recognition of plasma cell hyperplasia may be the first step in correct diagnosis.

In both smears and sections with an increased number of plasma cells there is occasionally some difficulty in differentiating between multiple myeloma and other diseases (sarcoid, Hodgkins), with marrows characterized by a plasmacytosis. Where the plasma cells were anaplastic, the diagnosis was readily made by smears or sections. In the more benign case a differentiation between the plasmacytosis associated with hyperglobulinemia and that due specifically to multiple myeloma was more accurately made by examination of sections.

5. Reticular cells (and fixed cells in general).

Very little attention has been paid to these cells in the past, since as already has been shown, they are only rarely demonstrable in smears. They are the site of three pathologic processes, iron storage, fat storage diseases, and phagacytosis of microorganisms.

A complete absence of iron in the marrow is the only pathognomonic feature of iron deficiency. Some diagnostic success has been attained by demonstrating absence of iron in smears[13]. However, since the iron is in reticular cells, and since the latter are only irregularly demonstrable in smears, the failure to demonstrate iron in a marrow smear is not as reliable a criterion as similar failure in marrow sections.

Increase in marrow iron is a more frequent occurrence with correspondingly greater significance than a decrease in marrow iron. In sections, one may not only recognize the presence of excess iron, but also make a rough estimate of the amount of iron and even of the duration of the disease causing the excess iron. Normally iron is seen as fine blue granules. With increasing duration and amount of storage of iron these granules change from blue to green, to yellow-green, to yellow and finally to brown as seen in the slide stained by hematoxylin eosin-azure II. With this change in color the granules change from soft and smudgy 1 to 2 micra granules to large crystalline, highly refractile masses reaching 8-12 micra in size. The latter occur only in patients with primary and secondary hemochromatosis, longstanding severe hemolytic anemia and/or numerous blood transfusions. Lesser degrees of iron storage are correlated with diseases characterized by an occult increase in hemolysis as in nephritis, leukemia, carcinoma and the collagen diseases. The recognition of excess iron is most important, since patients with an anemia associated with excess stores of iron will not respond to iron therapy.

Fat storage diseases though comparatively rare present difficult diagnostic problems. Since reticular cells are recognizable only sporadically in smears, it is no surprise to find that the diagnosis has been frequently missed in smears, but made by examination of sections[14]. In fact, in one case where the diagnosis had already been made, no Gaucher cells were found in the smears from a second marrow aspiration, whereas in the corresponding sections, half of the marrow was composed of Gaucher cells. Similar experience has been noted in other fat storage diseases.

Parasites or fungi are phagocytized by reticular cells. To demonstrate these organisms the reticular cells must be seen. In a rather limited experience with histoplasmosis, these parasites have been seen in sections but not in smears.

6. Foreign cells and structures.

The major abnormalities noted in the marrow are metastatic cancers, infectious granulomas, and lymphomas.

Though metastatic cancers are demonstrated fairly often in smears, my experience coincides with that of Weisberger[2], who found these cells more frequently in sections than in smears of aspirated marrow particles. In addition, the combination of cytology and architecture in the sections helps one to differentiate more accurately metastatic cells from stem cells. In smears this may be more difficult.

Sections have been of major importance in the diagnosis of one important group of diseases, the infectious granulomas. Sarcoid is included in this group because of the histologic structure of the sarcoid nodule. These patients present with a variety of symptoms and signs, varying from hemolytic anemia and splenomegaly to fever of unknown origin. In no case has an infectious granuloma been demonstrated in smears of the marrow, without being found in sections. However, failure to demonstrate the granuloma by no means rules out this group of diseases. It is now a routine procedure in this institution to check the marrow of every patient with a fever of unknown origin.

The marrow is frequently, perhaps invariably, involved, at least some time in the natural history of the lymphomatous diseases. Steiner's[15] studies have clearly demonstrated the frequency of Hodgkins tissue in the marrow. In a series of approximately 200 marrow aspirations in Hodgkins disease, specific lesions have been found only six times in sections and once in smears. Apparently the Hodgkins lesion is so fibrous that it is hardly ever aspirated from the marrow.

Estimation of the number of lymphocytes in smears has always been unreliable due to several factors. If the ratio of granulocytes to lymphocytes in the peripheral blood is decreased, there tends to be a contamination of the marrow smear by peripheral blood lymphocytes artificially increasing the percentage of lymphocytes. In normal and in abnormal conditions lymphocytes tend to occur in dense diffuse or nodular lymphatic tissue. Fortuitously smearing one of these areas will also result in a falsely high percentage of lymphocytes. On the other hand, because of preservation of the architecture in sections, one obtains a more accurate estimate of the relative amounts of myeloid and lymphatic tissue in these circumstances. Consequently the diagnosis of lymphosarcoma and benign chronic lymphatic leukemia has been made more frequently by study of sections than of smears.

7. Disease characterized by qualitative changes in the marrow.

In most cases of leukemia, multiple myeloma and pernicious anemia, the marrow is qualitatively abnormal. For example, in pernicious anemia there is the appearance of a new lineage of cells, the megaloblast, replacing the erythroblast. In acute leukemia, the marrow may be replaced by a single cell type to the virtual exclusion of normal marrow cells. Where so extreme degree of abnormality is found, and assuming preparation of smears by an adequate technic, examination of sections is not superior to smears as a practical clinical procedure.

Summary

Marrow smears have a well defined but narrow range of value. As in any other technic, errors may be avoided only by appreciating the limitations as well as the advantages of the method. Examination of smears is essentially a grossly qualitative procedure. No amount of counting of cells or application of complicated mathematical methods of analysis can hide the fact that the number and distribution of cells as seen in smears is as dependent upon physical factors governing the attachment of the cells to the marrow scaffolding and their spread along the slide as upon their number and distribution in the marrow. In essence

the smear technic is accurate only in those situations where there is an extreme degree of marrow abnormality in the sense of replacement of the marrow by a single type cell or cell lineage. If in addition no reliance is placed upon acellular smears, then a major source of error will be removed and the value of the technic further enhanced.

A major stumbling block to the adoption of the section technic has been the failure to utilize a method of preparing sections of marrow that will as adequately delineate the fine cytologic features of the marrow cells as is possible by utilization of smears stained by the Romanowsky dyes. The Maximow technic has now made it possible to prepare sections in which cell types are as clearly recognizable as in smears. This technic has opened up a new field of clinical pathology extending beyond the mere recognition of purely qualitative gross changes in the marrow.

(Bibliography available in the reprints of this article.)

The Insurance Examination

Preston J. Burnham, M.D.
SALT LAKE CITY

THE value of performing examinations for insurance companies is manifold to the physician who is beginning his practice. Not only do the several fees that come in each month serve to pay some of his overhead, but if the insurance clients are pleased with him, they will return to him for treatment of their illnesses, and send him their friends.

There is more to the problem than this, however. The young man in beginning his practice should realize many of the facts of insurance examining before he indulges in it—either part-time as most doctors do in the beginning, or as full-time careers. When the insurance agent has "sold" a client, it is mandatory that he have him examined by a physician as soon as possible—preferably that same evening, else the client may change his mind and either not buy any insurance, buy less insurance, or buy from another company.

Realizing these facts, when I started practice and assumed the responsibility of examining for an insurance company, I gave the agents a free hand to make an appointment for the client and THEN to call my office to confirm it. Thus I performed many examinations late at night, Sundays, holidays, in my office, at the client's place of business, and in their homes.

I feel that these considerations are, indeed, necessary if the physician is to do a good job for the agents and for the company. When his practice has developed he can limit examinations to his office, quit entirely, or continue, if his interests so indicate.

But the physician has another responsibility — of which conscience may remind him—to his patients. Despite the fact that patients and possibly agents may tend to look on the insurance physician as a lackey who fills out insurance forms, I have always approached them with the thought that, although the company sends me my checks, the client pays for it. Therefore, the client (my patient) who may not see a doctor once in ten years seems to be entitled to what the forms say—a complete physical examination preceded by a complete history. Examinations may average three-quarters of an hour in length.

I have found people with albuminuria who, on successive trips to the office to pass their specimens after lying down, have successfully received their insurance because of my proving the condition to be one of orthostatic albuminuria. A ten minute examination would have flunked the client. Unless a sink test had been performed!

The agency manager has called me to examine patients at their homes—"His weight used to be over 250 lbs., but is now only 194 lbs. Write that down, Pres, and you won't have to check him."

Unfortunately, I would discover a scale in the patient's bathroom, and would usually find that he weighed in at 215 lbs.! When the agent would learn of this, he would strongly suggest that I "fudge" a little because the man "desperately" wanted insurance. What to do?

On several occasions I have found hypertension and tachycardia at the first office call. After a half hour's talk or a return appointment, I have found both signs to be perfectly normal. Many clients have had a blood pressure of 180 over 100 even at the end of the examination. Although there is no added fee for so doing, it is necessary to have the client return several times for retaking of the blood pressure in order that he may have the opportunity to overcome any emotional reaction that he may have to a strange doctor. However, there were many clients who had told their agents of a definite hypertension. "Pres, this fellow gets real nervous on these exams. His pressure may be up a little, but don't be too hard on him. It doesn't hurt to fudge a little." Pressure consistently 180/100! What to do?

I recently examined a hardworking male patient who had light râles in the left apex following the unexplained loss of some ten pounds of weight in as many months. He said that he had had a normal chest x-ray some eight years before. When I explained that he might have a chest problem—disease or tumor—he was most grateful for my telling him, and planned to have an x-ray taken within a few days. I had promised to withhold the insurance examination report until I had seen the x-ray. However, he had to leave town in his work, and three months later had had no x-ray, probably due to the usual patient's procrastination.

Shortly after this the agency manager met me and was quite incensed. "You'll do no more examining for us. When you turn down clients for no good reason we don't want you. If you can't fudge a little once in a while to pass a fellow you are no good to us. You don't have to go over those people with a fine-tooth comb. You can't make money when you spend time on them, and neither can we."

There are, then, three guiding forces in the performance of an insurance examination:

1. Duty to the insurance salesman.
2. Duty to the insurance company.
3. Obligation to the client.

Under heading number 1, a physician may spend ten minutes on the examination, pass everyone that the agent sends to him, make more money faster, and be assured of the agent's loyalty for life.

Under number 2, the physician might be persuaded to disqualify many clients at the first visit or even in the first few minutes for fear of passing someone whose apparently shortened statistical life expectancy, based on a transient tachycardia, emotional hypertension, or orthostatic albuminuria, might help bankrupt the company.

Under number 3, the physician might spend a total of two or more hours on the patient over a period of a week in order to ascertain the presence of, or rather in trying to disprove, a truly disabling physical handicap. The physician may be led toward his third philosophy by two forces—a conscience which cannot be silenced, and a feeling of obligation to the patient whom he must warn of any early signs of disastrous handicap, and who, incidently, is paying the cost of the examination.

The physician who would dabble in insurance examining would do well to consider whether he wishes to do a $7.50 exam every ten minutes (including the sink test which is $45.00 per hour) and have a large insurance practice, or whether he will maintain his obligation to the patient and risk an early termination to his insurance examining career!

NEW AND IMPORTANT

ROLICTON*

(BRAND OF AMINOISOMETRADINE)

Simple b.i.d. Dosage for Positive Diuresis

THE GLOMERULAR FILTERING SYSTEM
Configuration of the renal glomerulus as revealed by the electron microscope.

(Illustration by Hans Elias)

THIS newest product of Searle Research is the only *continuously effective* oral diuretic that avoids *all* these disadvantages:

. . . Significant side effects
. . . Complicated dosage schedules
. . . Electrolyte disturbance
. . . Acid-base imbalance
. . . Fastness
. . . Known contraindications

ROLICTON has been found effective as an agent to eliminate, or greatly reduce the frequency of, mercurial injections.

DOSAGE IS SIMPLE. One tablet b.i.d. is usually adequate, following administration of four tablets the first day. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

SEARLE

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

In addition to helping states make monthly public assistance payments to certain indigent persons, the federal government for a number of years also has contributed to the cost of their medical care. Because the grants formula is somewhat complicated, and the amount of medical care varies with the states, this U. S. contribution cannot be fixed definitely. It is estimated at about 90 million dollars a year.

About a third of the states now deposit these federal grants—which must be matched 50-50—in a separate fund, from which the medical care costs are paid directly to the vendors, such as physicians, dentists, hospitals, nursing homes and druggists. The remaining two-thirds include medical care costs in monthly checks to the indigent, and expect these people to pay their own medical bills.

But beginning next July 1, this U. S.-state medical care arrangement is going to be drastically altered.

For one thing, the U. S. will increase its payments from the current $90 million a year to between $200 million and $300 million. For another, **all** medical care money under the new program will be put into a separate fund, from which the indigents' medical bills will be paid, in one way or another, by the state itself.

It is true that in some states the new program will not have much effect. This will be the case with those states that already have a substantial medical care program and see no reason for increasing it and with those unable to raise the matching money.

But the amount of money potentially available to each state is significant, and in most states the change-over from the old to the new systems will have an important effect on physicians and other vendors of medical care. For example, eight states will have "new" medical care funds in excess of 10 million dollars, if they put up half the money. California's potential fund is $27 million and New York's and Texas' more than $18 million each.

Before state welfare directors can start operating under the new program they will have to decide (a) whether they will require doctors to agree to a fee schedule, if one is not already in operation in their indigent care program, and (b) how the doctors will be reimbursed (whether through their societies or other mechanisms, or directly by the government). Some state welfare

officials already have approached state medical societies to talk over the situation.

(U. S. contributes to indigents in only four categories—the aged, dependent children, the blind and the disabled. For their medical care, it will offer states $3 per month for each adult and $1.50 for each child, money which the state must match. It is out of these funds that payments will be made for medical care.)

NOTES:

Because most applicants did not supply enough information, the council in charge of grants for medical research facilities approved only a handful of projects at its first meeting. Although $30 million was available, only $764,159 was allocated. Money went to seven institutions. However, the expectation is that the fund will be just about exhausted at the December meeting of the council, as more than 250 hospitals, schools and laboratories have asked for money.

First head of the new National Library of Medicine is the man who steered the Armed Forces Library through the last seven troubled years — Col. Frank B. Rogers. He is on loan from PHS, which is in charge of the new institution to be built up around AFML.

Hearings will be held probably in December by the House Interstate and Foreign Commerce committee on federal aid to medical education. The expert panel system will be used, instead of lone witnesses. Currently the committee staff is analyzing information received in response to questionnaires sent out to about 60 organizations interested in medical education.

A six-man advisory committee, named by Secretary Folsom, is attempting to work up suggestions that will help hospitals improve care and reduce costs. Some possibilities: central cafeterias for ambulatory patients, light housekeeping work done by some patients themselves.

Regional Small Business Adminstration offices now are taking applications for loans to three types of health facilities — hospitals, nursing homes, and medical and dental laboratories. Institutions must be "small" and must be run for private profit.

ORGANIZATION

ABSTRACT OF MINUTES* HOUSE OF DELEGATES of the COLORADO STATE MEDICAL SOCIETY

Eighty-Sixth Annual Session
September 5, 6, 7, 8, 1956

Stanley Hotel
Estes Park, Colorado

FIRST MEETING
Wednesday, September 5, 1956

Vice Speaker Carl Swartz of Pueblo called the House to order at 2:00 p.m., and recognized Dr. C. C. Wiley, Chairman of the Committee on Constitution, By-Laws, and Credentials.

Dr. Wiley presented the Committee's report as printed in the House of Delegates Handbook and amended it by reversing the names of Drs. John A. Davis and S. P. Esposito of Arapahoe County inasmuch as Dr. Esposito is the Alternate for Dr. James M. Kennedy, and Dr. Davis is the Alternate for Dr. Milligan. Inasmuch as Dr. Jerome Textor has moved from the state, Dr. Lloyd Wright will now be the Delegate from Clear Creek Valley Society and Dr. Kenneth Platt will be his Alternate. Dr. R. J. Groeger was appointed Alternate Delegate from the Northeast Colorado Society in the place of Dr. Robert Ludwick. Seventy-four accredited delegates (more than a quorum) answered the roll call.

On motion, the reports of the Credentials Committee were adopted.

Speaker Condon delivered an opening address calling attention of the delegates to the importance of policy decisions to be made at this session, recommending that all reference committees meet simultaneously in the afternoon of this date in order to expedite their work, and recommending a change in the order of business to provide for an executive session just before adjournment in order to comply with the By-Laws amended and adopted a year ago regarding confidential reports of the Board of Councilors.

The House by vote adopted the Speaker's proposals and suggested to the Committee on Constitution, By-Laws and Credentials that the order of business be permanently amended with

*Condensed from the shorthand and sound recorded record of Earl S. Wirtz, Certified Shorthand Reporter. Reports referred to but neither reproduced nor abstracted herein were distributed to all members of the House of Delegates in advance of the Annual Session in the printed "House of Delegates Handbook" or were distributed to all members of the House in mimeographed form. Copies of all such reports are on file in the Executive Office of the Society, available for study by any member of the Society.

regard to a time for an annual executive session.

On motion regularly seconded and carried without dissent, the minutes of the Interim Session of the House, held February 14 and 15, 1956, were adopted, without correction, as published in the May, 1956, issue of the Rocky Mountain Medical Journal.

(Speaker Condon and Vice Speaker Swartz alternated in presiding over the remainder of the session. Secretary Sethman conducted a recheck of the Roll Call to list late arrivals.)

Reports of Board of Trustees:

President Robert T. Porter presented the Annual Report of the Board of Trustees as printed in the Handbook and read the following supplemental report:

"Medicare" Plan

Through AMA publications, most Delegates should be aware of the passage of Public Law 569, signed last June 7 by President Eisenhower, which inaugurates medical care of military dependents by civilian physicians and hospitals.

This law will be implemented by the Department of Defense, through the Department of the Army and all state medical societies, effective December 8, 1956.

Rapid work has necessarily been done by the Department of Defense, in close and most friendly cooperation and liaison with the American Medical Association, in order to develop the necessary regulations to carry this law into effect. Special work has had to be done by your State Society officers and Trustees to get ready on our own level to do our part in observing this law and making it workable to the advantage of both patients and physicians.

In essence, the program will provide for the dependents of military personnel the same sort of "home-town care plan" which has been operating on a smaller scale for certain beneficiaries of the Veterans Administration the last few years. Wives and other dependents of Armed Forces personnel who now get their medical care from institutions like Fitzsimons Army Hospital, Fort Carson Hospital, etc., will continue to do so. But there are many such dependents who live too far from military hospitals to use them. Beginning this December, civilian physicians and hospitals will be paid by the government for providing their care.

Before presenting the exact motions adopted by the Board of Trustees, it might be well to summarize a few points:

Public Law No. 569 is the law of the land, passed by Congress and signed by the President.

Although some may disagree with the philosophy of the government providing complete in-hospital medical care for all dependents of active-duty military personnel, that philosophy is now law, regardless of the residence of the dependents. It had already been law for a great many years so far as dependents were concerned who lived on or near a military post.

Public Law 569 recognizes "organized medicine" as has perhaps no other medical law ever passed by the Congress. It gives the state medical societies and their designated agents contracting power with the government.

Colorado is fortunate in being one of the eight states having had several years' experience with the Veterans Home Town Medical Care Program, albeit on a small scale. From this experience we have learned how such a medical care program can be administered efficiently and to the general satisfaction of patient and doctor.

Under these circumstances, and with the further background of having conferred at length with the representatives of the Department of Defense as well as with other states similarly situated, your Board has adopted the following motions:

A. The Board of Trustees recommends to the House of Delegates that the Colorado State Medical Society cooperate with the Department of Defense in administering Public Law 569.

B. The Board recommends to the House of Delegates that the Board of Trustees be designated as the Society's Negotiating Authority with the Department of Defense in the implementation of Public Law 569.

C. The Board recommends to the House of Delegates that it direct the Board of Trustees to engage Colorado Medical Service, Inc., as the Contracting and Fiscal Agent for this Society in the implementation of the Military Dependent Medical Care Program.

D. The Board of Trustees requests the House of Delegates to instruct the Board of Trustees,

as the Society's Negotiating Authority with the Department of Defense, to use the Preferred Blue Shield Plan fee schedule as a base level for fee schedule negotiations.

E. The Board requests the delegates to instruct the Board of Trustees that any contract negotiated with the Department of Defense authorize payment only to physicians for professional services rendered by them.

President Porter next presented the following report at a meeting agreed to by the joint Trustees-Regents Liaison Committee, on August 28 and approved by the Board of Trustees for presentation to the House of Delegates.

Medical School Report

This is a report from the Board of Regents, supplementing the original communication of last February, submitting to the House of Delegates for your concurrence, the polices of the Regents with respect to the treatment of patients in the proposed full-pay Teaching Wing, as follows:

1. The Regents reiterate their intention to operate the new Wing only for purposes of teaching and in so doing will so allocate available beds to the various specialties and sub-specialties with respect to both full-time and volunteer faculties as to insure no deviation from this purpose.

2. In order that there be an understanding with respect to the size of this new wing where charges will be made to patients, it is the policy of the Regents to currently construct a facility of not to exceed 150 beds; and with respect to the future it would be the policy of the Regents not to exceed in such a wing, two beds for each junior and each senior student.

3. As to out-patients, it will be the Regents' policy not to exceed seeing pay-patients in excess of those necessary to fill the beds permitted. All out-patient activity shall be for teaching purposes only.

4. As to medical and surgical statements, all bills would be rendered in the name of the individual doctor, such doctor having designated that payment is to be made to the medical school as his fiscal agent.

5. It will be the policy of the Regents that the proceeds of such statements and all other forms of charges involving personal services shall be placed in a fund which will be used only for payment of salaries to doctors, it being understood that such fund may include salaries of pre-clinical and research teachers. No part of the proceeds of such billings for personal services shall be used for any purpose other than salaries.

6. As to compensation, it will be the policy of the Regents to themselves set the salaries of the various members of the full-time and, if desirable, the members of the volunteer faculty, and with respect to the amount of such salaries it is the intention and desire to pay within the limits of available funds, salaries which shall be competitive as compared with other medical schools.

7. Upon construction of the new wing, it will be the policy of the Regents to restrict all members of the full-time faculty to teaching activities within the physical facilities of the medical school and hospitals, including the new wing; it being understood, however, that as orginally indicated, teaching activities can be conducted in public hospitals, veterans' hospitals, and certain others where specialized work is done such as the National Jewish Hospital; provided, however, that all funds from such services shall accrue to the salary fund specified in paragraph 5 above.

8. As to the volunteer faculty, it will be the policy of the Regents to determine the allocation of beds and appropriate recognition.

9. It is the desire of the Board of Regents that all of the above items of implementation, together with such other items as may hereafter develop, be discussed not less than quarterly at meetings between the Board of Regents or a Committee of the Board and your Liaison Committee to the end that all matters of mutual interest and concern be brought to a conclusion satisfactory to all.

President Porter further presented the annual audit of the Society's finances prepared by the firm of Collins, Peabody and Masters, Certified Public Accountants. After discussion of the Board of Regents report, the reports were referred to the Reference Committee on Board of Trustees and Executive Office. Dr. James M. Perkins then presented a mimeographed minority report objecting to the new budget proposed by the Board of Trustees in the Handbook. This report was also referred to the Reference Com-

mittee on Board of Trustees and Executive Office, after discussion by the House.

Nomination

President Porter read the following Citation and on behalf of the Board of Trustees, nominated Dr. Unfug for a Certificate of Service:

CITATION
of
GEORGE A. UNFUG, M.D.
For a Quarter-Century of Unselfish Medical Statesmanship.

Medicine in Colorado and especially in Pueblo is proud to claim a medical statesman like George Unfug as its own. He began his lifetime hobby of unselfishly serving his medical colleagues and his community in 1930 as Secretary of his County Medical Society, and from that important if unsung position went on to serve for many years as a Pueblo Delegate to his State Society, as President of his County Society and finally—during the difficult war closing years of 1945-46, as one of the youngest Presidents of the Colorado State Medical Society in our organization's long history.

But that was not all. He did not forget opportunities for civic and governmental service, as county chairman of his political party for many years and frequently delegate to its state and national conventions, as radiological consultant to the Colorado Selective Service System throughout World War II after he was disappointed by physical rejection for armed service active duty, and for six years as a member and finally President of the Colorado State Board of Medical Examiners.

He also served local, state and national organizations in his specialty, including membership on the Commission on Legislation and Public Policy and the Commission on Public Relations of the American College of Radiology.

After his Presidency of our State Society, he served us with great distinction for eight more years as a Delegate to the American Medical Association. He gave so much of himself to all these activities while at the same time maintaining a busy medical practice, that one year of his career had to be sacrificed to convalescence from a break in health. His health restored, he buckled back into fresh harness and in the last five years has served on a half-dozen more American Medical Association committees, sometimes on two of them simultaneously.

Although he recently insisted upon retiring from the national House of Delegates, and although we are convinced his career of medical statesmanship is far from finished, he has earned distinctive recognition from our Society over and above his past-Presidency. The Board of Trustees therefore agrees with the nomination by the Pueblo County Medical Society, and presents to the House of Delegates, the name of George A. Unfug, M.D., for the Society's Certificate of Service.

It was moved and seconded and unanimously carried that the nomination be confirmed.

Dr. Herman W. Roth presented the Annual Report of the Board of Councilors as printed in the Handbook and submitted the following supplemental report: Both reports were referred to the Reference Committee on Professional Relations.

Supplemental Report of the Board of Councilors

As our report in the Handbook indicated, this Board held a special meeting on August 11, 1956. Among other matters, the Board received a request from the Committee on Constitution, By-Laws and Credentials for a definitive interpretation of the By-Laws, regarding a question that had arisen in both that Committee and the Board of Trustees.

The question arose when it became known that one of our component societies has permitted a physician to continue as an Active Member of the local society and to vote in its proceedings, while under suspension from the State Society for nonpayment of dues. The question was put to the Board of Councilors to determine whether or not our Constitution and By-Laws can be construed to permit membership in a component society without simultaneous membership in the State Society. The Board of Councilors was aided in this matter by an exhaustive study of the question that had been prepared by the Society's legal counsel, Mr. J. P. Nordlund.

The Board found, after studying all applicable material, that membership in the State Society and in its component societies is indivisible. Al-

(Continued on Page 1030)

ACHROMYCIN

ACHROMYCIN*

Tetracycline *Lederle*

for prophylaxis and treatment of

obstetric infections

Posner and his colleagues[1] have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

Other investigators have shown ACHROMYCIN to be equally useful in surgery and gynecology and virtually every other field of medicine. This outstanding antibiotic is effective against a wide variety of infections. It diffuses and penetrates rapidly to provide prompt control of infection. Side effects, if any, are negligible.

Every gram of ACHROMYCIN is made in Lederle's own laboratories and offered *only* under the Lederle label—your assurance of quality. It is available in a *complete* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.
SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

For more rapid and complete absorption. Offered only by Lederle!

dry-filled sealed capsules

[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

Lederle

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AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

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(Continued From Page 1027)

though no single section of these documents presently states this fact in so many words, a great many sections of both the Constitution and the By-Laws cannot be otherwise construed.

However, to avoid any future confusion and any need for another study of this kind, the Board has recommended to the Committee on Constitution, By-Laws and Credentials that an appropriate amendment to the By-Laws be offered re-stating this principle of organized medicine in unequivocal terms.

Also at this Board's August 11 meeting, correspondence was received from the Board of Supervisors on two subjects upon which the Board of Councilors cannot act at the present time. At the same time the Board of Councilors approved non-controversial nominations by component societies for certain membership reclassifications.

Also at the August 11 meeting the Board conducted a hearing and entered findings and decisions which the By-Laws require be reported to the House in executive session. At the convenience of the House, therefore, we will request a brief executive session for that purpose.

The report of the Board of Supervisors as printed in the Handbook was referred to the Reference Committee on Professional Relations.

President Porter submitted a personal report as follows:

This has been in most respects a successful year. I would like to discuss some of the reasons for the successes and failures which have occurred.

Credit for any successes that have been achieved must go to all the members of the Society. Their cooperation, willingness to work, and friendliness has been constant and most effective. To the best of my knowledge every committee of this Society has met at least once and with real enthusiasm studied the problems that fell within its scope. In a gratifying number of instances they have delved into new areas for expansion. On only four occasions during the entire year was it necessary to drop members from committees in order to carry out the House of Delegates' directive that two unexcused absences from a called committee meeting was cause for replacing the member. I mention this only to point out the fine attendance at committee meetings.

I should like particularly to commend Dr. John Zarit. As chairman of the Public Health Committee, he attempted to attend all of the meetings of the eleven sub-committees under his supervision. Obviously this was impossible but he met with most, if not all, of the committees at some time during the year and with several on frequent occasions.

The Public Policy Committee under the chairmanship of Dr. Harry Hughes was most efficient and was able to handle all of its business in a limited number of meetings. The work of Dr. Frank McGlone and the A.M.E.F. Committee deserves special mention for producing the highest amount ever contributed to that fund in this state. It speaks well for the committee and for the growing interest in the project.

I could go on and report on the fine work of the many other valuable committees of the Society, but time does not permit, and their reports are in the Handbook.

The Board of Trustees and other official boards have worked long, industriously, and in harmony. Among these is one to whom this Society owes a great deal but whose work is known only to a relatively few. That man is Dr. Walter Metz who has been on the Finance Committee for three years and who has so ably directed the finances of the Society that even in a year like this, by radically limiting our operations, he has been able to bring the Society through in the black.

Last but not least, I would be extremely remiss if I were not to give due credit to the work of our Executive Office. With a limited number of employees the office has continued its duties with a fine spirit of cooperation. When it seemed for the first seven or eight months of the year that we were going into the red financially, many of our employees gave overtime work without billing the Society for it. At the end of the year, the Finance Committee, with the approval of the Board of Trustees, corrected this; but our Society as a whole owes the Executive Office staff a vote of appreciation for this splendid gesture of loyalty.

When we began the year, it seemed to me that there were three major problems confronting the Society; namely, the medical school study regarding a pay pavilion; two, our relations with organized labor in the Trinidad area and the Tri-County area; and, three, the problem of a building to house our State Medical Society. As has been reported earlier, I believe that the discussions of the Medi-

cal Society Committee with the Board of Regents regarding the problem of the full-pay teaching pavilion has led to a satisfactory solution. Relations between the two groups is at a very high level, which I believe it is possible and essential to maintain.

Labor relations will be discussed in other reports, but I believe they, too, are now better understood and that out of the studies by various committees of this Society and the AMA will come a solution that is satisfactory both to the Society and to labor.

The third problem, that of a State Society building, has not been satisfactorily solved due to difficulties in securing the land which we assumed was available. Definite progress, however, has been made.

We have in Colorado a growing vital medical society with real prestige both locally and nationally. One cannot go to a meeting of the House of Delegates of the AMA without realizing the real respect in which the Colorado State Medical Society is held. To continue this, we must give our Society more adequate finances. While the Society ends this year in the black, this was done at the expense of omitting activities of the Society which should not have been omitted. We did not send representatives to as many meetings as in the past. The liaison established at these meetings had been good for the prestige of the Society. If the present policy is continued, our society is bound to lose its ranking. It is my earnest plea that the House of Delegates insist that this Society be adequately financed to meet the many significant demands made upon it. Then we can have a Society of which we will continue to be proud.

Let me take this opportunity to thank you, the members of this Society, for the privilege of being your President this past year. It was a high honor and I appreciate it. Also let me again thank all of the committee chairmen and committeemen and Board members for their cooperation and help throughout the year, for without every member's help it could not have been a success.

Speaker Condon referred President Porter's report to the Reference Committee on Board of Trustees and Executive Office. President-elect George Buck had no personal report, and no other officer, member of the Board of Trustees, Board of Councilors, or Board of Supervisors submitted a personal report.

The report of the delegates to the AMA as published in the Handbook was referred to the Reference Committee on Professional Relations.

The report of the Foundation Advocate was unavailable. Secretary Sethman explained that due to the early date of the Annual Session it has been impossible for the auditors to complete both the audit of the Society and the audit of the Colorado Medical Foundation, which is in the hands of the International Trust Company at Denver. No action was taken.

The report of the Executive Secretary as printed in the Handbook was referred to the Reference Committee on the Board of Trustees and Executive Office.

Dr. Wiley presented the second report of the Committee on Constitution, By-Laws and Credentials in the Handbook, and a mimeographed supplemental report distributed to Delegates. There being no discussion, the reports were referred to the Reference Committee.

The following printed reports were referred to Reference Committees: Committee on Health Education, including the Subcommittee on School Health, Committee on Library and Medical Literature, Committee on Medical Education and Hospitals, Subcommittee on Medical Student Loan Fund, Committee on Medical Service, Committee on Blood and Tissue Banks, Subcommittee on Distribution of Physicians, Subcommittee on Emergency Medical Services, Subcommittee on Hospital-Professional Relations, Committee on Indigent Medical Services.

Dr. Stuck, on behalf of the Subcommittee on Intraprofessional Insurance, presented the following supplemental report:

(Continued on page 1034)

NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.

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the first and only ataraxic-corticoid

taraxoid*

prednisolone and hydroxyzine

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combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

*Trademark

(Continued From Page 1031)

Professional Insurance Problems

The Committee recommends that the facts contained in its study, along with the facts reported by the Medicolegal Committee in the August Rocky Mountain Medical Journal, be studied by an insurance actuary and through him be brought to the attention of the Colorado State Insurance Commission and the affected insurance companies, for the purpose of reduction of professional liability insurance rates.

We further recommend that all matters pertaining to professional liability insurance in the future be referred directly to the Medicolegal Committee.

Chairman Stuck further read a communication to Mr. Kraus dated August 28 with reference to the malpractice insurance program offered by the International College of Surgeons.

The following printed reports were then referred to the Reference Committees: Subcommittee on Medical Care of Veterans, Subcommittee on Physician-Nurse Relations, Subcommittee on Prepayment Services, Medicolegal Committee, Committee on Public Health.

Public Policy Supplement

Chairman Harry Hughes submitted a supplemental report of the Public Policy Committee with reference to, one, that contribution by physicians to hospitals, or indeed any community-sponsored project, is strictly an individual matter, and this is the policy of the State Medical Society; further, that the supplying of penicillin to near-indigent patients with rheumatic heart disease should be channeled through the retail druggists and that this decision should be made known to the Colorado Heart Association and the Colorado Retail Druggists Association. There being no discussion, the supplemental report and the printed Handbook report were referred to the Reference Committee on Legislation and Public Relations.

The following further printed reports were referred to Reference Committees: Committee on Rocky Mountain Medical Conference, Committee on Scientific Program, Committee on American Medical Education Foundation, Committee on Blue Shield Benefits for Old Age Pensioners.

Blue Shield Fees

Dr. Frank McGlone reported for the Blue Shield Fee Schedule Advisory Committee as follows:

The Committee met Tuesday night, September 4, in the Stanley Hotel. Immediately preceding this meeting, the Executive Committee reviewed all requests received, and made certain recommendations to the Advisory Committee.

Anesthesiology:

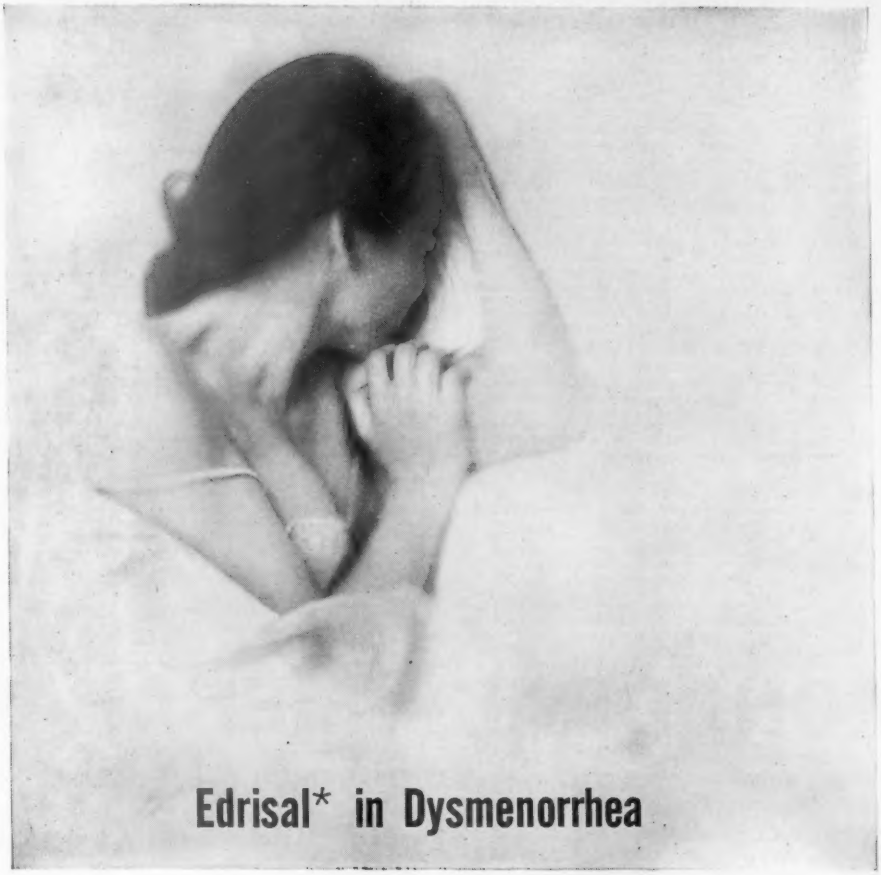
The anesthesiologists, through the Chairman of their fee committee, requested increases in the Plan's allowance for Obstetrical Anesthesia and for anesthesia rendered during Intra-cranial, Intra-thoracic, and Intra-carbiac surgery; and further, the inclusion of benefit for anesthesia for dental surgery.

Your Committee approved the increase requested for Obstetrical Anesthesia when rendered by a physician—such increase to provide up to $25.00 on a time basis, the present allowance being $7.50—but denied the request for increased allowance for anesthesia rendered during the three types of surgery noted. Your Committee also denied the request for inclusion of benefit for anesthesia rendered during dental surgery. This latter action was taken in view of the fact that Blue Shield's Subscription Agreement stipulates that benefit for anesthesia is allowed for "necessary anesthesia" rendered in connection with surgical services covered by the Plan, and that "dental surgery" is NOT covered under the agreement.

The Advisory Committee also approved the recommendation that when surgical or obstetrical services and anesthesia are rendered by the same physician, payment shall be made only for the surgical or obstetrical procedures.

Orthopedic Surgery:

A committee of the Rocky Mountain Orthopedic Association reviewed a portion of the Fee Schedule and submitted a recommendation reducing the Plan's



Edrisal* in Dysmenorrhea

A "satisfactory antispasmodic for use in spastic dysmenorrhea is . . . Benzedrine* Sulfate"[1]—one of Edrisal's 3 ingredients. Edrisal's other ingredients are aspirin and phenacetin.

'Edrisal' Analgesic—Antispasmodic—Antidepressant

Two tablets every 3 hours

Smith, Kline & French Laboratories, Philadelphia

Formula: Each 'Edrisal' tablet contains:

Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.)	2.5 mg.
Aspirin	2.5 gr.
Phenacetin	2.5 gr.

1. Medical Gynecology, ed. 2, Philadelphia, 1950 *T.M. Reg. U.S. Pat. Off.

payment for some twenty (20) procedures. The Committee approved these reductions as submitted, and commended the Orthopedic Association for its action. Your Committee recommends that all Specialty Groups give consideration to similar action where indicated.

Neurosurgery:

The Neurosurgeons requested increases in the standard Plan's payment for Pneumoencephalography, and the Standard and preferred Plan's allowances for Myelography. Your Committee denied these requests.

Heart Catheterization:

The Advisory Committee was requested to consider the appropriate allowance for certain diagnostic x-ray and laboratory services performed in connection with Heart Catheterization. It was agreed that there was insufficient information available on which to take action, and your Committee tabled this request, and asked that the Executive Committee study the matter further, reporting to the full Committee at the 1957 Midwinter Clinical Session.

Assistant Surgeon:*

Pursuant to a motion passed at your Advisory Committee's meeting on February 13, 1956, a six-man subcommittee was appointed to study Blue Shield's benefit for an Assistant Surgeon and make such recommendations as seemed in order relative thereto.

This subcommittee surveyed all Component Societies and Specialty Groups, and then endeavored to correlate the finding of the survey. It was noted that no conclusion could be drawn as to what specific action should be taken, because the recommendations resulting from the survey were so varied.

As a consequence, the subcommittee—after carefully weighing the financial standing of Colorado's Blue Shield Plan, and in consideration of not only the various recommendations received but also of the methods employed by other Blue Shield Plans—submitted the following recommendations:

1. Eliminate the asterisk (*) method of denoting the procedures for which the services of an assistant surgeon are available under the Preferred Blue Shield Plan and substitute therefore the regulation appropriately worded in the Manual, that ANY procedure commanding an allowance of $100.00 or more (including those marked for 'Individual Consideration' in which the ultimate allowance is $100.00 or more) is eligible for an assistant surgeon on authority of, and at the discretion of, the attending surgeon. It was understood that the use of an assistant for a procedure commanding a fee of less than $100.00 would be infrequent and such would not constitute a Blue Shield benefit.

2. That the allowance for the assistant surgeon be deducted—on the attending surgeon's authority—from the currently listed allowance for the surgical procedure(s) performed in accordance with the folowing table:

Allowance for Surgery	Allowance for Assistant
$100 to $149	$15
150 to 249	25
250 to 300	35

3. That the Plan's service statement be revised to include a section wherein the operating surgeon could note whether or not a paid assistant had been required and, if so, could authorize payment to the assistant surgeon by name. In the event that such were left blank, or the word "NONE" given, even though the surgeon may have been assisted by a partner, or other associate, Blue Shield will presume the fee for service was included in the total allowance and that a service benefit subscriber will not be subject to an assistant surgeon's billing.

4. That the Plan advise all subscribers thus affected of the payments made to each physician.

Your Advisory Committee, after considerable discussion, voted to accept the Subcommittee's recommendation with but one amendment. This amendment was made to give elasticity to the payment to the Assistant Surgeon—at the Operating Surgeon's discretion—and provides that the amounts payable out of the listed fee shall be $15 to $25 for procedures for which the Plan benefit is $100 to $149; $25 - $35 for procedures commanding $150 to $249; and $35 - $50 for procedures commanding $250 to $300. It was agreed that if a specific amount was not designated by the Surgeon, the Plan would automatically pay the lesser of the foregoing.

The report of the Committee on Military Affairs was referred to the Reference Committee on Miscellaneous Business.

Dr. William H. Halley, Chairman of the U.M.W.A. Fund Liaison Committee, recommended that the Pennsylvania Plan, which was de-

*This section was not adopted. See Page 1050.

veloped by the Pennsylvania State Medical Association covering relations with the U.M.W.A. Fund be given to the Reference Committee for their information and recommendation. This plan was added to the report and it was referred to the Reference Committee on Professional Relations.

Constitution Amended

Unfinished business from the previous Annual Session consisted of the third report of the Committee on Constitution, By-Laws and Credentials in the Handbook, being a general amendment of the Constitution and By-Laws, changing the name of the "Board of Supervisors" to the "Grievance Committee." It was moved and seconded and carried unanimously that the amendment be adopted.

The next order of business was the election of a Nominating Committee. The following Delegates were nominated: Drs. Eugene B. Ley, Pueblo; John L. McDonald, El Paso; Lawrence L. Hick, Delta; Fred D. Kuykendall, Weld; David P. Halfen, Clear Creek Valley; Harry C. Hughes, Denver, and Harlan E. McClure, Prowers.

There being no further nominations, they were closed and on motion carried unanimously the above members were elected by acclamation as the Nominating Committee.

AMA "Guiding Principles"

Dr. Perkins submitted a proposal for amendment of the AMA "Guiding Principles for Management and Union Health Centers" (which was referred to the Reference Committee on Legislation and Public Relations) as follows:

This entails only the addition of a new principle. To include the following principle as Principle 1 in the Section headed "Guiding Principles" on page 10 of the AMA Booklet and renumber the later paragraphs:

"1. **Free Choice of Physician.** Eligible participants shall be given an opportunity at the beginning of the period of their eligible participation and at any time thereafter to elect to receive their medical care from the health center staff and facilities or in lieu of payment to the health center assume the responsibility for providing their own medical care."

On behalf of the Denver Medical Society Dr. Lubchenco stated he had possible changes in dues, as applicable to full-time physicians in the Veterans Administration and on the staff of the University of Colorado School of Medicine, to present to a Reference Committee. The matter was referred by the Speaker to the Reference Committee on Constitution, By-Laws and Credentials.

Dr. William Lipscomb submitted a group of informal suggestions for the society's future activities, emphasizing greater unity in political activity. His proposals were referred to the Reference Committee on Board of Trustees and Executive Office.

Speaker Condon reminded the House that it had adopted the suggestion for an Executive Session. Drs. John Amesse and John Simon were appointed Sergeants-at-Arms to clear the room of all not entitled to attend an Executive Session.

A motion was made that a non-Delegate member of the Las Animas County Society be seated. Suggestions followed for the seating of other non-Delegates. Following general discussion and advice from the society's attorney Dr. Newman made a substitute motion that only the regularly constituted members permitted in Executive Session be allowed to remain on this occasion. The substitute motion was seconded and carried without dissent.

The Sergeants-at-Arms thereupon cleared the House of all unauthorized persons and the House

(Continued on Page 1040)

highly successful . . .

- faster relief of pain, photophobia
- better control of inflammation, edema, allergy
- effective against common eye pathogens
- extremely well tolerated

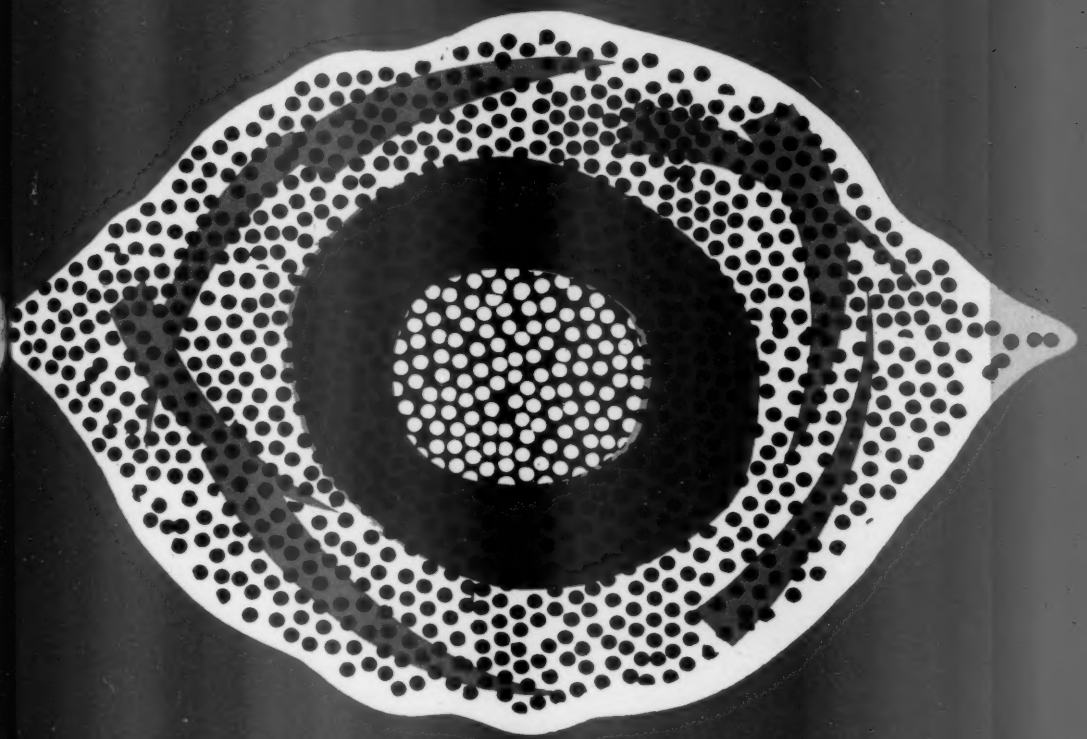
now available

for inflammatory, allergic, infectious or traumatic eye conditions amenable to topical therapy—rapid, potent, topical Meti-steroid and anti-infective action

supplied: METIMYD Ophthalmic Suspension-*Sterile*: prednisolone acetate (METICORTELONE Acetate) 5 mg. per cc. (0.5%) suspended in an isotonic buffered and preserved solution of sulfacetamide sodium 100 mg. per cc. (10%), 5 cc. dropper bottle. METIMYD Ointment with Neomycin: each gram contains 5 mg. prednisolone acetate (METICORTELONE Acetate), 100 mg. sulfacetamide sodium and 2.5 mg. neomycin sulfate (equivalent to 1.75 mg. neomycin base); ⅛ oz. tube, boxes of 1 and 12.

METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
METICORTELONE,® brand of prednisolone.
*T.M.

. . in topical eye therapy



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(prednisolone acetate and sulfacetamide sodium with neomycin sulfate)

Ointment with Neomycin

• antibacterial • antiallergic • anti-inflammatory

Schering

(Continued From Page 1037)

went into Executive Session. Upon arising from Executive Session the following special report of the Board of Trustees was entered in the Minutes and was referred to the Reference Committee on Professional Relations:

The Board of Trustees has received and studied the report of the A.M.A. Committee on Medical Care of Industrial Workers, and presents to the House the following recommendations:

1. The Board of Trustees expresses its deep appreciation to the American Medical Association and to Dr. William A. Sawyer and the other members of the AMA Committee who studied and reported on this problem.

2. The Board of Trustees recommends that the "Directive of 1954" issued by the Area Administrator of the UMWA Welfare and Retirement Fund be modified to conform to existing agreements between the UMWA Welfare Fund and the American Medical Association.

3. It is recommended that the UMWA Welfare Fund, nationally, be requested to direct the Area Administrator to consult with and work through the Liaison Committee of this Society as further contemplated by the Fund's national agreement with the American Medical Association.

4. It is further recommended that the Las Animas County Medical Society is hereby directed to make full use of the services of the UMWA Liaison Committee of the Colorado State Medical Society.

5. It is further recommended by the Board of Trustees that the Las Animas County Society be directed and encouraged to bend all possible efforts to secure the reaccreditation of the Mt. San Rafael Hospital in Trinidad in order that patients in that area can receive the highest quality of medical care.

6. It is recommended that subsidization of physicians by the UMWA Welfare Fund be discontinued except wherever it is absolutely necessary as agreed on by the Area Administrator and the Liaison Committee.

7. The Board of Trustees recommends that a reconstituted UMWA Liaison Committee consisting of five members be appointed. Definitions of the function of this Liaison Committee shall be as follows:

a. This Committee shall meet with the Area Administrator at least quarterly, and oftener if specific problems are presented.

b. It shall be the authority of this committee to receive complaints from the Area Administrator relative to competency of or abuses by participating physicians. If the Liaison Committee finds that these charges are substantiated, it shall be the committee's responsibility and authority to remove such physicians from the list of participating physicians.

c. It is further recommended that in the event the Liaison Committee is unable to resolve a disagreement between the UMWA Fund and any Colorado physicians, the Liaison Committee shall report all information to the Board of Trustees for its action.

d. It is further recommended than an additional function of the Liaison Committee is to receive and act upon complaints arising from physicians in the state relating to the Area Administration of the UMWA Walfare Fund.

e. It is recommended that the Area Administrator be required to consult with the Liaison Committee before issuing any directives relative to medical practice as it relates to the UMWA Welfare and Retirement Fund.

8. The Board of Trustees is equally cognizant of the implications in the American Medical Association Committee's report concerning this Society's cleaning its own house and keeping it clean, and therefore assures the House of Delegates that the Board of Trustees will use its authority under the By-Laws to file disciplinary charges before the Board of Councilors whenever and wherever indicated.

There being no further business for the day, the House adiourned at 5:30 p.m. to reconvene at 2:00 p.m. Thursday, Sept. 6, 1956.

SECOND MEETING
Thursday, September 6, 1956

Speaker Condon called the House to order at 2:00 p.m. The Roll Call disclosed 59 accredited members of the House present, more than a quorum. Dr. K. A. Platt was seated to replace Dr. Wright for Clear Creek Valley.

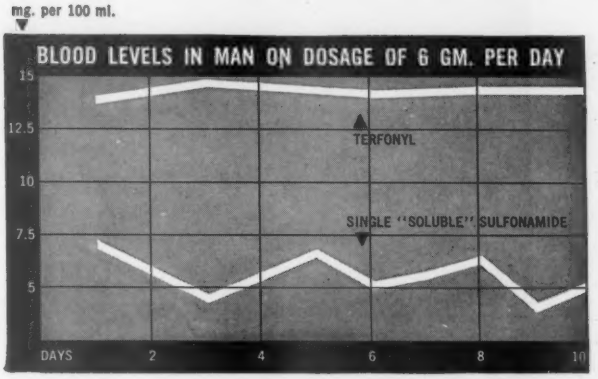
Secretary Sethman read the condensed Minutes

(Continued on Page 1044)

maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



*Ther. Ther., D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

***Terfonyl Tablets*, 0.5 Gm., bottles of 100 and 1000.**
***Terfonyl Suspension*, 0.5 Gm. per 5 ml., pint bottles.**

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

SQUIBB

(Continued From Page 1040)

of the House of Delegates' first meeting on September 5. There being no corrections or additions, the minutes were adopted as read.

The Grievance Committee (Board of Supervisors), through a supplemental report presented by Dr. Beebe, recommended that a committee be appointed to study the problem of establishing a State Accrediting Committee for small hospitals similar to the National Joint Commission on Accreditation of Hospitals. The Grievance Committee also recommended a study be made to ascertain the feasibility of establishment of a fund or some method of insuring the members of the committee against damage suits. It was further recommended that the By-Laws of the society be changed so that two members of the committee will come from the Denver Society with overlapping two-year terms. These recommendations were referred to Reference Committees.

Chairman Bradford Murphey presented the following report, which was adopted section by section and as a whole:

Report of Reference Committee on Professional Relations

(a) Your Reference Committee recommends approval of the report of the Board of Councilors as printed on page 15 of the Handbook.

(b) Your Committee recommends approval of the report of the Board of Supervisors as printed on pages 15 and 16 of the Handbook.

(c) Your Committee recommends approval of the report of the Subcommittee on Blood and Tissue Banks of the Medical Service Committee as printed on page 24 of the Handbook, and recommends that this committee be urged to set up tissue banks as soon as possible.

(d) Your Committee recommends approval of the report of the Committee on Medical Service for the Distribution of Physicians as carried on pages 24 and 25 of the Handbook.*

(e) Your Committee recommends approval of the report of the Medical Service Committee Subcommittee on Hospital-Professional Relations, as printed on pages 25 and 26 of the Handbook.

(f) Your Committee recommends approval of the report of the Subcommittee on Intraprofessional Insurance, as carried on page 26 of the Handbook, with the following modification: That the sentence reading, "Some have competent legal counsel, while others have substandard counsel," in section (a) be stricken. The Reference Committee further approves of the recommendation of the chairman of the Insurance Committee presented yesterday, that the Medical Society employ an insurance actuary to present and interpret its recommendations to the Insurance Commissioner.

(g) Your Committee recommends the approval of the Medical Service Subcommittee on Physician-Nurse Relations as printed on page 27 of the Handbook.

(h) Your Reference Committee recommends approval of the report of the Medicolegal Committee as carried on pages 28 and 29 of the Handbook.

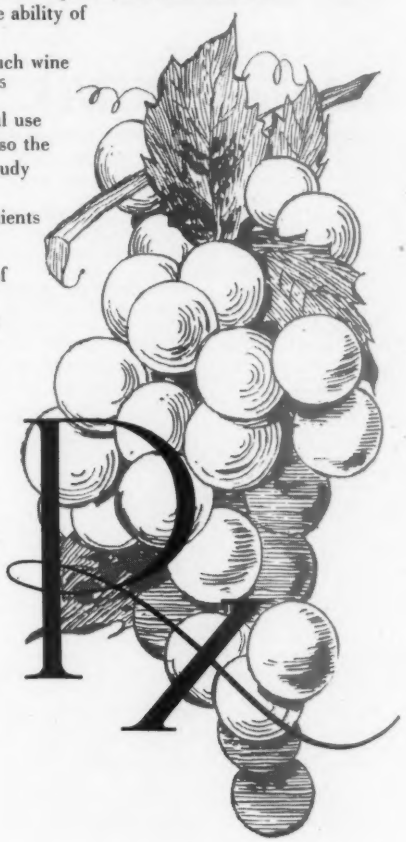
(i) Your Committee recommends approval of

*After adjournment of the Session it was discovered that this approval is invalid so far as it recommends transferring functions of the Committee on Distribution of Physicians to another Committee unless the By-Laws were appropriately amended, and no such amendment was adopted.—Secretary's note.

Why wine in Anorexia?

It has been popularly held that various types of alcoholic beverage are appetite stimulants, but objective laboratory investigations have clearly shown that alcohol itself, under controlled conditions, acts as a depressant to appetite.[1, 2]

Wine, however, the classic beverage of moderation, used as an aperitif, has been found to exert a profound stimulating effect on appetite and on the ability of both normal and anorexic patients to detect faint odors.[3] Goetzl and his co-workers have attributed this effect to such wine components as tannic acid, tartaric acid and acetic acid.[4, 5]



In actual clinical trials, Goetzl has reported the successful use of dry wines in increasing not merely the appetite, but also the food intake of patients suffering from anorexia. In one study on the appetite-stimulating action of wine, the average daily caloric intake in a substantial group of anorexic patients was increased from an average of 773 to 1228 calories.[6]

The above excerpts are taken from the brochure "Uses of Wine in Medical Practice" which describes the results of recent laboratory and clinical research on the medical attributes of wine. Herein are reported the latest findings on the value of wine as a stimulant to flagging appetite, as an aid to digestion, as a vasodilator, as a daytime and night-time sedative.

A copy of the brochure is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco, California.

1. Margulies, N.R.; Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:1 (Jan.) 1950.
2. Irvin, D.L.; Ahokas, A.J., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:97 (Oct.) 1950.
3. Goetzl, F.R.: Permanente Found. M. Bull. **8**:72 (April) 1950.
4. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **9**:119 (Oct.) 1951.
5. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. **20**:17 (Jan.) 1953.
6. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

the report of the Committee on the Rocky Mountain Medical Conference as carried on pages 35 and 36 of the Handbook.

(j) Your Committee recommends approval of that portion of the report of the Board of Trustees which is printed in the third paragraph on page 11 of the Handbook.

(k) Your Committee recommends approval of that portion of the Report of the Board of Trustees which is printed in the second paragraph of the report on page 11 of the Handbook.

Your Committee further approves that section of the Special Report* of the Board of Trustees to the House of Delegates on September 5, dealing with the report of the Committee on Industrial Workers of the American Medical Association, labeled Section 2, with the following modifications:

1. That the word "direct" occurring in line 2, paragraph 3, be changed to "urge."
2. That paragraph 3 end with the word "Society" in line 3, and that the language "as further contemplated by the Fund's national agreement with the AMA," be stricken.
3. That the word "be" be substituted for the phrase "is hereby" in line 2 of paragraph 4.
4. That the word "required" at the end of the first line in section e of paragraph 7 be stricken and the term "requested" be substituted.
5. Your Committee further recommends that the UMWA Liaison Committee proposed in paragraph 7 be set up as a subcommittee of the Board of Trustees and that it shall have not only the functions set forth in sections a, b, c, d, and e, but that it also shall be charged with the responsibility of working out specific plans and techniques for the improvement of medical care in the entire area of industrial relations. Your Committee further recommends that the name of this Liaison Committee be changed and that it shall henceforth be called "The Committee on Industrial Relations of the Colorado State Medical Society" to bring the nomenclature parallel with that of the AMA.

Dr. Porter: I hope you are all cognizant of the fact that you are setting up a committee with very broad powers, because this committee will have the power to put men on the labor union list or take them off. That should be clear to the House of Delegates. We are trying to copy the Pennsylvania Plan where the State Medical Society decides what physicians shall be on the list of the labor unions. They will have an appeal to a higher authority which has not yet been spelled out by the Board of Trustees. It is quite a powerful committee that is being set up and I think you should know that. It is working well in Pennsylvania. We are in favor of it.

Dr. Cyrus W. Anderson, Denver, submitted the report of the Reference Committee on Board of Trustees and Executive Office, which, after discussion, was adopted section by section and as a whole as follows:

Report of the Reference Committee on Board of Trustees and Executive Office

Your Committee first considered the first portion of the Report of the Board of Trustees as printed in the Handbook on pages 8, 9, and 10. It was noted in paragraph 3 on page 9 that the budget had not received unanimous approval, that there had been one dissenting vote, so it was decided that more careful scrutiny be given to this matter to determine if possible the reason or reasons for the disagreement. Your Committee also noted paragraph 5 on page 10, together with

*See page 1040.

a one and one-half page list entitled "Memorandum to the Finance Committee" dated August 20, 1956, prepared by the Executive Secretary at the request of the Finance Chairman (copy of which you do not have, but which is available for your perusal), a list of appropriations reduced or denied during the past two years. These economy moves were undertaken to avoid a deficit. Your Committee commends the Board for its endeavors to economize, but at the same time questions the advisability of continuing to deny appropriations which would hamper the distinction this society has long held as being one of the top leaders in organized medicine. Your Committee also deplores the mention of a possibility of a ceiling to be placed on the remuneration of the executive staff as was mentioned in a minority report, as this cannot have any other effect than to disrupt the morale of that office.

This Committee recommends the adoption of this section of the Trustees' report to the end of the first paragraph on page 11 in your Handbook.

Budget

(b) In order to simplify the hearing of testimony, continuing discussion in the same vein in the matter of finances, your Committee next considered the budget printed in your Handbook, beginning on page 14, entitled "Supplement to the Report of the Board of Trustees." Your Committee very carefully considered this budget, requesting the presence of the Chairman of the Finance Committee and the Executive Secretary, as well as the Treasurer of the society.

Each and every item of the budget was considered separately to determine the basis for the alleged "padding" mentioned in the minority report submitted by Dr. James Perkins. Many hours were spent deliberating this matter. Every witness desiring to speak was given the privilege of airing his views as many times as he wished. Many questions were propounded to the Chairman of the Finance Committee, Dr. Walter Metz, who graciously presented his testimony containing facts and figures concerning each and every item in the budget. This Committee wishes to thank and commend Dr. Metz most highly for the many, many hours he has so diligently devoted to the finances of this society.

Your Committee unanimously approved the budget as printed on pages 14 and 15 in your Handbook and recommends its adoption, realizing full well that approving this budget will mean one of two things, of which all Delegates should be aware: Namely, it will mean either an increase in dues or a deficit in the budget. Your Committee was also unanimous in the opinion that there should not be a deficit in the budget. Your Committee does not believe it consistent with sound business principles either to build up a substantially greater reserve at this time, or to dissipate within a short time the present reserves which have slowly and carefully been built up over a long period of time.

Dr. Walter Metz, Chairman of the Finance Committee, is present and will be most happy to go through each and every item of the budget as he presented it before your Reference Committee last evening. This presentation will consume about an hour to an hour and a half, but it is well worth listening to if you would care to hear it.

(Secretary's Note: This section of the Reference Committee report was discussed at length by Drs. Perkins, Liggett, Murphey and Metz, who answered questions from the floor, and it was then adopted by a divided vote of 43 to 10.)

Medical School

(c) Your Committee next considered that section of the report of the Board of Trustees beginning with the third paragraph on page 12 of your Handbook entitled "Trustees-Regents Liaison," together with a statement presented to the Liaison Committee of the Colorado State Medical Society consisting of nine proposals and signed by three members of the Board of Regents and which was read on the floor yesterday.* Your Committee recommends that you accept this portion of the report of the Board of Trustees together with the statement presented by the Liaison Committee embodying the policies laid down by the Board of Regents of the university and further recommends that negotiations and good liaison be continued between the University and the Colorado State Medical Society with these policies as presented by the Regents as a basis for further friendly negotiations.

(d) Your Committee next considered that section of the report of the Trustees concerning the report of Dr. John S. Bouslog, our Representative to the Rocky Mountain Radio Council. The Committee concurs wholeheartedly with this section of the report and recommends its approval.

(e) Your Committee next considered that portion of the Trustees' report concerned with a building and the matter of increased office space for the society. Your Committee recommends approval of this section of the report.

(f) Your Committee considered the Board's subcommittee report on Indoctrination and recommends approval of this section of the report.

(g) Your Committee considered the report of the Advisory Committee to the Woman's Auxiliary together with a report submitted by Mrs. Haley, which was not available to the Board at the time the Handbook went to press. The Committee commends Mrs. Haley and her committee for its work and we recommend approval of this section of the report.

(h) Your Committee next considered a supplemental report of the Board of Trustees read before this House yesterday, the first and last paragraphs of which were submitted to this Reference Committee. The first paragraph concerned the audit prepared by Collins, Peabody and Masters, Certified Public Accountants, as to the finances of the society as of August 31, 1956, copies of which have been distributed. Your Committee recommends approval of this audit.

State Compensation Fund

(i) The Committee next considered item number 3 of the supplemental report of the Board of Trustees which has to do with the appointment of an Advisory Committee to the State Compensation Insurance Fund. As this motion to appoint an advisory committee to the State Compensation Insurance Fund specified seven members—an Internist, a General Surgeon, an Orthopedist, a Radiologist, a Neurosurgeon, a Psychiatrist, and a Plastic Surgeon, and did not mention a General Practitioner or an anesthesiologist, and perhaps other specialties which should be represented, and did not specify the tenure of office or the method of appointment, the Committee therefore recommends that before appointing said Advisory Committee that the Board seriously consider the suggestions embodied in this report, and that the House empower the Trustees to work out the details to create such a continuing committee.

*See page 1026.

(Secretary's Note: This section of the Reference Committee report was discussed at length by Drs. Porter, Covode, Platt, Metz and Speaker Condon, and then was adopted without dissent.)

(j) The Committee considered and approved the report of the Foundation Advocate as carried on page 16 of the Handbook.

(k) The Committee next considered the supplemental report of the Board of Trustees entitled "Minority Report" prepared by Dr. James M. Perkins. We regret any disruption of morale which may have occurred in the Executive Office as a result of this supplemental report, but trust that these difficulties will be ironed out satisfactorily. While the Committee appreciates the interest and the endeavor of Dr. Perkins, your Committee felt that there had not been "padding" of the budget. We also felt that the Board in its appropriations within the past year had stayed within the budget only because of economy, and curtailment of activities many of which we feel should be resumed. Realizing that increasing the necessary office space with its necessary remodeling costs money, and the inevitable increase of cost of supplies, travel expense—in fact, an increase in practically every item in the budget—we unanimously recommend that the minority report be **not** approved.

(l) Your Committee considered next the report of the Executive Secretary. The material in this report is factual. Your Committee heartily agrees with Mr. Sethman, who commended his entire staff for their diligence and loyalty and we agree that Miss Virginia Pullen and Mrs. Frances Wilhelm should be specifically named for their outstanding contributions to the efficiency of the office staff during the last two years.

President Commended

(m) Your Committee also considered the report of your President, Dr. Robert T. Porter, read to you yesterday, in which Dr. Porter commented on the activities of the various committees and committee chairmen, and gave special commendation to Dr. Zarit, Chairman of the Public Health Committee, Dr. McGlone, Chairman of the A.M.E.F. Committee, and Dr. Walter Metz, Chairman of the Finance Committee. Your Committee agrees with Dr. Porter in his reiteration that the Colorado State Medical Society is one of the leaders nationally, and agrees with his conclusion that we should continue to go forward, not backward by curtailing our activities. We wish at this time to commend Dr. Porter most highly and thank him for the unlimited hours he has spent during the past year in the service of this society. Your Committee felt that there has never been a President who has worked harder or more conscientiously than has Dr. Robert T. Porter. The society shall forever owe him a debt of gratitude. Your Committee recommends the acceptance of the report of the President with high commendation.

As Chairman, I wish at this time to thank the members of my Committee who spent many hours until far after midnight listening to testimony and deliberating and preparing this report. The members of this Committee were: Dr. John W. Bradley, Dr. Fred Kuykendall, Dr. Gatewood C. Milligan, Dr. B. T. Daniels, Dr. J. Lawrence Campbell and Dr. Harry Hughes.

Chairman Robert D. Patterson submitted the report of the Reference Committee on Scientific Work which was adopted section by section and as a whole:

Report of the Reference Committee on Scientific Work

(a) Your Reference Committee recommends the approval of the report of the Committee on Library and Medical Literature as printed on page 23 of the Handbook.

(b) Your Committee recommends approval of the report of the Committee on Medical Education and Hospitals as carried on page 23 of the Handbook, and wishes to commend this Committee for its very excellent work in this field.

(c) Your Committee recommends approval of that section of the report of the Committee on Public Health pertaining to Geriatrics, as printed on page 30 of the Handbook.

(d) Your Committee recommends approval of the report of the Committee on Scientific Program as carried on page 36 of the Handbook, and wishes to compliment this Committee on its very effective programming.

Report of the Reference Committee on Legislation and Public Relations

Chairman William A. Liggett submitted the report of the Reference Committee on Legislation and Public Relations, which was adopted section by section and as a whole as amended as follows:

(a) Your Reference Committee recommends approval of the section of the report of the Board of Trustees which appears on page 12 of the Handbook and consists of that paragraph under the sub-heading "Comprehensive Care" and the sub-paragraph following with the suggestion that the final clause of the first sentence of the sub-paragraph beginning with the word "but" be changed to read "but the society feels that the only sound basis for the successful operation of a prepaid medical care plan must be the principle of the free choice of physician."

(b) Your Committee recommends approval of the supplemental report of the Board of Trustees which deals with the problem of medical care for dependents of military personnel under Public Law 569, which was distributed in mimeographed form to the House at the first session. Your Reference Committee recommends that item C in the last page of the Supplemental Report under the list of motions passed by the Board of Trustees be changed to read as follows: "The Board recommends to the House of Delegates that it direct the Board of Trustees to engage Colorado Medical Service, Inc., as the fiscal agent for this society in the implementation of the military dependents medical care program and that the Board of Trustees be empowered to use its discretion as to the designation of the contracting agent, whether it be Colorado Medical Service, the Colorado State Medical Society, or any other feasible contracting body which in the opinion of the Board is competent to represent physicians in the negotiation of a contract with the Defense Department."

(Dr. Liggett explained that the above changes were made on the advice of Mr. Nordlund, the Society's legal counsel.)

(c) Your Committee recommends approval of the report of the Committee on Medical Service as carried on page 24 of the Handbook.

(d) Your Committee recommends approval of the report of the Subcommittee on Indigent Medical Services as printed on page 26 of the Handbook.

Uniform X-ray Fees

(e) Your Committee recommends approval of the report of the Subcommittee on Prepayment Services, as printed on pages 27 and 28 of the Handbook, and recommends that the House of Delegates adopt the policy that all state compensation fee schedules be uniform for all physi-

cians, and that the problem of discrepancies in x-ray services be negotiated through the utilization of an adjudication board rather than through fee differentials.

(Secretary's Note: This section of the Reference Committee report was discussed by Drs. Ryan, Halfen, Liggett, Hughes, Daniels and Speaker Condon, and then was adopted without dissent.)

(f) Your Committee recommends approval of the report of the Public Policy Subcommittee on Legislation as printed on page 34 of the Handbook.

(g) Your Committee recommends approval of that section of the Public Policy report beginning with the last paragraph on page 34 and ending at the end of the whole report on page 35 of the Handbook.

(h) Your Reference Committee took note of paragraph 2 of the Supplemental Report of the Public Policy Committee which was distributed in mimeographed form at the time of the first meeting, dealing with correspondence relative to the Trinidad problem. Your Committee recommends approval of this section of the Supplemental Report.

(i) Your Committee recommends approval of the report of the Blue Shield Fee Schedule Advisory Committee on pages 37 and 38 of the Handbook and of the Supplemental Report presented to the House at the first meeting.

Your Reference Committee, after conferences with members of the Fee Schedule Committee, recommends that the fee for surgical assistance as printed in paragraph 2, page 3, of the mimeographed report be changed as follows: "From $15.00, $25.00, and $35.00, to $20.00, $30.00, and $45.00," respectively, for procedures in the fee ranges printed in the Supplemental Report. (This paragraph not adopted; see below—Secretary.)

(Secretary's Note: This section of the Reference Committee report was discussed at length by Drs. Richards, Fisher, Ryan, Bosworth, Metz, Curfman, Perkins, Merritt, McLaughlin, Hughes, Tucker, Childs, Vincent, Patterson, Anderson and Milligan.)

(Following discussion, Dr. Fisher moved, seconded by Dr. Milligan, that those parts of this report relating to fees for Assistant Surgeons be **re-referred** to the Blue Shield Fee Schedule Advisory Committee for further study. The motion carried, not without dissent, by viva voce vote. On motion of Dr. Liggett the remainder of the report of the Blue Shield Fee Schedule Advisory Committee, as recommended by the Reference Committee, was approved, without dissent.)

(j) Your Committee approves the suggested change in the Guiding Principles for Evaluating Management and Union Health Centers, submitted by Dr. James Perkins at the first meeting of the House of Delegates. Dr. Perkins suggested including in the Guiding Principles as printed on page 10 of the AMA booklet, a paragraph ensuring free choice of physician as Principle No. 1, and renumbering the existing principles in order following the new paragraph 1.

I thank the members of the Reference Committee for their arduous work in preparing this report.

Report of Reference Committee on Public Health

Chairman Fred Roukema submitted the following report which was adopted section by section and as a whole:

(a) Your Reference Committee recommends approval of the report of the Committee on Health Education as carried on pages 21 and 22 of the Handbook.

(b) The Reference Committee wishes to commend Dr. Zarit, his Committee and his Subcommittee chairmen for their excellent work during the past year in public health. In particu-

lar the Committee wishes to recognize their efforts in their effective work in handling the difficult problems relating to the distribution of polio vaccine.

Your Committee recommends approval of the report of the Committee on Public Health as carried on page 29 of the Handbook.

(c) Your Committee also recommends approval of the reports of the Subcommittees on Automotive Safety, page 29 of the Handbook; on Cancer Control, page 29 of the Handbook; on Cancer Conference, page 30 of the Handbook; on Crippled Children, page 30 of the Handbook; on Geriatrics, page 30 of the Handbook; on Industrial Health, page 31 of the Handbook; on Maternal and Child Health, page 31 of the Handbook; on Mental Health, page 31 of the Handbook; on Rehabilitation, page 32 of the Handbook; on Rural Health as printed on page 32 of the Handbook (except as modified by the General Public Health Committee's report previously approved); also your Committee recommends approval of the report of the Subcommittee on Sanitation, page 32 of the Handbook, and wishes to recommend that the Sanitation Subcommittee take a more active part in the solution of the many severe pollution problems throughout the state; we recommend approval of the report of the Subcommittee on Tuberculosis Control, page 32 of the Handbook, and the financial report of the Cancer Conference.

(d) Your Committee wishes to note the formation of the Rocky Mountain Cystic Fibrosis Association and to approve the objectives of that association.

Report of Reference Committee on Constitution, By-Laws, and Credentials

Chairman C. C. Wiley submitted the following report which was adopted section by section and as a whole, without dissent, and the proposed amendments were declared adopted:

(a) Your Reference Committee recommends approval of the report of the Board of Trustees as carried on page 11, paragraph 3, of the Handbook, recommending repeal of the Standing Rule concerning officer and committee orientation as adopted by the House of Delegates on February 16, 1955.

(b) Your Committee recommends adoption of the Standing Rule on Certificates of Service as amended in yesterday's supplemental report to the House of Delegates.

(c) Your Reference Committee recommends the approval of the report of the Committee on Constitution, By-Laws and Credentials as carried on pages 20 and 21 of the Handbook and of the supplemental report.

(d) Your Committee recommends that the resolution presented to it by Dr. Lubchenco concerning increasing the length of Active Junior Membership in the Society from two to four years be referred to the Board of Trustees of the State Society and the Board of Trustees of the Denver County Medical Society, for joint consultation and special report at the next Annual Session.

(e) Your Reference Committee recommends that the following amendment as proposed by the Speaker of the House be adopted: "Amend Chapter V, Section 2, entitled 'Order of Business' by inserting after 'No. 13, New Business, a new No. 14 as follows: '14. Executive Session Business, if Any,' and by renumbering 'Adjournment' as No. 15."

All of the amendments approved in the above report were adopted without dissent.

Report of Reference Committee on Miscellaneous Business

Chairman Charles G. Freed submitted the following report which was adopted section by section and as a whole without dissent:

(a) Your Reference Committee recommends the approval of the report of the Subcommittee on Medical Student Loan Fund as carried on page 23 of the Handbook and commends this committee for their efforts in this direction.

(b) Your Reference Committee recommends approval of the report of the Committee on Emergency Medical Services as printed on page 25 of the Handbook.

(c) Your Committee recommends approval and commends the report of the Committee on American Medical Education Foundation as printed on page 37 of the Handbook, with the exception of the last sentence of this report. Your Committee neither approves nor disapproves this part of the report, but feels the question of an involuntary assessment is one which would warrant a good deal of thought and discussion before any definitive action be taken.

(d) Your Committee recommends the approval of the report of the Committee on Military Affairs as printed on page 38 of the Handbook.

Report of the Committee on Nominations

Chairman John L. McDonald presented the report of the Committee on Nominations as follows:

Your Committee on Nominations respectfully offers the following slate of nominations for positions to be filled by election at this Eighty-Sixth Annual Session:

For President-elect: Gatewood C. Milligan of Englewood.

For Vice President: C. Walter Metz of Denver.

For Treasurer, 3-year term: William C. Service of Colorado Springs.

For Trustee, 3-year term: Bernard T. Daniels of Denver.

For Councilor, District No. 2, 3-year term: Roger G. Howlett of Golden.

For Councilor, District No. 8, 3-year term: Herman W. Roth of Monte Vista.

For Councilor, District No. 9, 3-year term: Scott A. Gale of Pueblo.

For members of the Grievance Committee, formerly known as the Board of Supervisors, each for a 2-year term, six to be elected: Freeman H. Longwell, Denver; Gordon H. Vandiver, Otero; George G. Baldertson, Montrose; Robert H. Smith, El Paso; Robert A. Hoover, Chaffee; Walter M. Boyd, Weld.

For Delegate to the AMA, 2-year term: Kenneth C. Sawyer of Denver.

For Alternate Delegate to the AMA, 2-year term: Irvin E. Hendryson of Denver.

For Foundation Advocate: Walter W. King of Denver.

For Speaker of the House of Delegates: Carl W. Swartz of Pueblo.

For Vice Speaker of the House of Delegates: Frank B. McGlone of Denver.

For the place of the 90th Annual Session to be held in 1960: Tentatively, Estes Park, Colorado, provided that the Board of Trustees after investigation of the possibilities shall approve.

There was no unfinished business, and no delegate offered new business.

President Porter: It would be most unappreciative if I did not say, "Thank You" for this most flattering report of Dr. Anderson's Committee, approved by the House of Delegates, for

the work of our Society this year. I certainly appreciate it and thank you all so much.

Speaker Condon obtained unanimous consent of the House, and Secretary Sethman presented a new motion picture film entitled "The Doubting Doctor," issued by the AMA, which will be available later for showing to component societies.

The House then adjourned at 5:00 p.m., to reconvene at 8:00 a.m., September 8, 1956.

THIRD MEETING
Saturday, September 8, 1956

Vice Speaker Swartz called the House to order at 8:00 a.m. After some delay, the Roll Call disclosed 39 accredited delegates present, more than a quorum. By proper procedure the following changes in seating of the Delegates and Alternates was made: Alternate A. F. Pierce for Delegate John W. Bradley; Alternate M. A. Hetrick for Delegate James W. McMullen; Alternate C. W. Eisele for Delegate F. B. McGlone; Alternate C. A. Hager for Delegate C. A. McLauthlin, Sr.; Alternate R. C. Beethe for Delegate J. O. Clanin; Alternate A. S. Rumley for Delegate Robert Patterson; Alternate Russell Hibbert for Delegate F. Kuykendall.

Condensed Minutes of the September 6 meeting were read by the Secretary. There being no additions or corrections, the Minutes were approved as read. At the request of Vice Speaker Swartz, Executive Secretary Sethman re-read the report of the Nominating Committee.

Supplemental Report of Nominating Committee

Chairman J. L. McDonald then submitted the following report which was filed:

Dr. Robert A. Hoover of Salida wishes to withdraw his name from consideration for re-election to the Grievance Committee (Board of Supervisors). He has served on this Board for four years and we think we should accede to his request.

We would like to submit in his place the name of Dr. Ligon Price of Hayden, Colorado.

Election of Officers

Vice Speaker Swartz declared that nominations were still in order from the floor of the House and called for any further nominations for the office of President-elect. There being no further nominations for that office, the Vice Speaker declared nominations closed and Dr. Gatewood C. Milligan of Englewood was elected by acclamation to succeed Dr. George R. Buck of Denver, for a one-year term.

Vice Speaker Swartz declared Dr. Milligan elected and appointed Drs. Bonham and Liggett to escort Dr. Milligan to the stand. Dr. Milligan acknowledged the applause of the House and spoke as follows:

Dr. Milligan: Gentlemen, I thank you for your approval, but I do question your judgment in this action. Frankly, I am just scared to death! I am not just making the usual conventional show of humility; I certainly am a most humble man this morning. There is nothing that I have prized more in my life than the approbation of my fellow practitioners of medicine, and for that I am deeply grateful. The tasks that this election imply are, I fear, beyond my capabilities, so we will certainly have to have all the help from you that is possible. That is not just when you are called on for help, for I am going to have to be needled and cajoled and stimulated to bring forth the capabilities that are not striving for utterance in my makeup. If you fellows will do

that, we will muddle through some way. I do thank you for this honor that certainly exceeds, I am sure, my capabilities.

There were no further nominations for the office of Vice President, the Vice Speaker closed the nominations, and Dr. C. Walter Metz of Denver was elected by acclamation.

There were no further nominations for Treasurer for a three-year term to succeed Dr. William C. Service of Colorado Springs, the Vice Speaker closed the nominations, and Dr. Service was elected by acclamation to succeed himself.

There were no further nominations for the office of a Trustee for a three-year term to succeed Dr. C. Walter Metz of Denver; the Vice Speaker closed the nominations, and Dr. Bernard T. Daniels of Denver was elected by acclamation.

Speaker Condon and Vice Speaker Swartz then proceeded, by independent actions in each instance, to conduct the election of all remaining nominees submitted to the House by the Nominating Committee, there being no nominations from the floor, and the House elected those nominees in each instance by acclamation. Additional officers so elected are as follows:

Councilor for District No. 2, Dr. Roger Howlett of Golden to succeed himself for a three-year term.

Councilor for District No. 8, Dr. Herman W. Roth of Monte Vista to succeed ihmeslf for a three-year term.

Councilor for District No. 9, Dr. Scott A. Gale of Pueblo to succeed himself for a three-year term.

Six members of the Grievance Committee (Board of Supervisors), each for a two-year term:

Freeman H. Longwell, Denver County Medical Society.

Gordon H. Vandiver, Otero County Medical Society.

George G. Baldertson, Montrose County Medical Society.

Robert H. Smith, El Paso County Medical Society.

Ligon Price, Northwestern Colorado Medical Society.

Walter M. Boyd, Weld County Medical Society.

Delegate to the American Medical Association for a two-year term: Dr. Kenneth C. Sawyer of Denver.

Alternate Delegate to the American Medical Association for a two-year term: Dr. Irvin E. Hendryson of Denver.

Foundation Advocate: Dr. Walter W. King of Denver to succeed himself.

Speaker of the House of Delegates to succeed Dr. William B. Condon of Denver: Dr. Carl W. Swartz, Pueblo.

Vice Speaker of the House of Delegates to succeed Dr. Carl W. Swartz of Pueblo: Dr. Frank B. McGlone of Denver.

Estes Park, Colorado, was selected as the place for holding the Ninetieth Annual Session to be held in 1960, provided that the Board of Trustees, after investigation, shall approve.

Additional Trustees' Report

President Porter submitted a Supplemental Report of the Board of Trustees which was adopted section by section and as a whole without dissent, as follows:

Since last reporting to you on Wednesday of this week, the Board has held additional meetings and should report the results of those meetings.

(a) The Board received some days ago, a report from Mr. Gilbert S. Cooper of the AMA Journal regarding his survey of our Rocky Mountain Medical Journal which the Board had requested him to make and which was referred to in our report in the Handbook. The Board could not complete its study of this report in time to report to the first meeting of the House of Delegates, and therefore reports at this time.

(b) Mr. Cooper's recommendations as a result of his survey are largely technical ones regarding the mechanics and the system of contracting for the Journal's publication and will be put into effect. However, two of his major recommendations are of interest to the House of Delegates and one actually requires action by the House of Delegates. One of these, not requiring your action, and which the Board has already approved, calls for mailing the annual directory publication in February or March of each year separately from the Journal. This will be effective with the 1957 directory. The one requiring your action is Mr. Cooper's conclusion that the so-called 25-75 formula upon which the Journal's overhead costs are currently paid is incorrect. Most members of the House will recall that after Mr. Cooper's first survey the Board of Trustees two years ago recommended that the Journal's adjusted gross income be computed and that 25 per cent of this adjusted gross income be remitted to our Society's General Fund as reimbursement for the Society's carrying of the Journal's overhead in terms of salary, rent, etc. Mr. Cooper's re-survey indicates that this formula is unfair to the Journal fund and therefore unfairly holds down either the Journal's reserve fund or its monthly publication size. The Finance Committee of your Board of Trustees and your Executive Office staff have in turn studied this matter and agreed partially, but **only** partially, with the percentages Mr. Cooper's survey would indicate. The Board of Trustees has in turn studied this matter and recommends that instead of paying 25 per cent of the Journal's adjusted gross income to the General Fund for overhead purposes the figures for the current fiscal year be set at 22 per cent. Mr. Cooper had recommended an even lower figure but your Board believes that 22 per cent is a proper figure at least for the next year. To do this requires a change in the Standing Rule of the House of Delegates which was adopted two years ago at the time the Board of Trustees first recommended the 25 per cent figure. We now therefore recommend that by adoption of this report the House amend its Standing Rule to the extent of changing those figures as indicated.

(c) The Board received the following letter from Dr. Ward Darley, President of the University of Colorado:

"Dear Dr. Porter:

"At its meeting on August 17 the Regents discussed your suggestion that some way might be found whereby the offices of the Colorado State Medical Society might be housed upon the Denver Campus of the Medical Center. The Regents directed me to write you indicating while this letter is not to be taken as a commitment, if it should be the official desire of the Society to work something out with the University, the Regents will be willing to give the matter every consideration."

The Board voted to direct a letter to the Regents of the University of Colorado stating that we appreciate their letter and while we are not able at this moment to accept this offer because of the Society's financial position, we hope they will continue their offer in order that we may submit an official request at a later date.

(d) This Board of Trustees has recently learned that officials of the AMA might welcome an invitation from this Society to hold its 1960 Clinical Session in Denver. The Clinical Session is customarily held the week following Thanksgiving. Like our own Society the AMA plans its convention sites four years in advance and decision on the site of the 1960 Clinical Session of the AMA will be made by the AMA Board of Trustees in October or November of 1956. The Board therefore recommends that the House of Delegates authorize a formal invitation to the AMA to hold the 1960 Clinical Session in Denver. In this connection it should be noted that the new hotel now under construction by Webb and Knapp, Inc., has committed itself for the fall of 1958 and has already booked other conventions for 1959. Therefore, using the Navy term, the new hotel should have a good shakedown cruise before the AMA would come to Denver in 1960.

(e) The Board of Trustees is well aware of the fact that at certain previous meetings of the Society held in Estes Park since World War II, accommodations and services at the Stanley Hotel were not up to the standards that the Society had learned to expect in the pre-war years. The Board is also keenly aware of the fact that those standards have been more than restored and therefore recommends to the House of Delegates that a sincere vote of appreciation be extended to the cur-

rent management of the Stanley Hotel, for the very effective quality and extremely courteous service extended the officers of the Colorado State Medical Society and its entire staff.

(f) Later this morning at the General Session all Delegates will hear in the report of the Necrology Committee the name of Lyman W. Mason, M.D. The Board of Trustees believes that the passing of Lyman Mason should be recognized by the House of Delegates as well as by the Necrology Committee. Lyman Mason became Assistant Editor of our Rocky Mountain Medical Journal just before World War II and when our Editor, Dr. Douglas Macomber, entered active duty with the Army in 1942, Dr. Mason became Acting Editor and served as our Editor throughout that war and for several months afterward, returning the Editorship to Dr. Macomber in 1946. At that time he became Associate Editor and Chairman of the five-state Editorial Board of the Journal. His many years of service in that position and also as Chairman of the Advertising Committee of the Journal constituted outstanding service largely unsung and unappreciated. Nonetheless the work he did for us as Trustees and for you as members of the House of Delegates will long live as a monument to his devotion to his colleagues.

Second Report of the Reference Committee on Legislation and Public Relations

Chairman William A. Liggett submitted the following report which was adopted section by section and as a whole without dissent:

(a) Your Reference Committee considered the Supplemental Report of the Grievance Committee (Board of Supervisors), concerning itself with the establishment of a Committee for Accreditation of small hospitals at the state level. Your Reference Committee recommends approval of this section of the Grievance Committee's report and suggests that in a study of its makeup, such a committee might possibly include representation from the Colorado Hospital Association, the Colorado State Board of Health, and the Colorado State Medical Society.

(b) The Reference Committee considered the second paragraph of the Grievance Committee's supplemental report which has to do with establishing some mechanism for legal protection against suits for members of the Grievance Committee, Board of Councilors, and other committees of the society which conceivably might be the targets of libel or damage actions. Your Reference Committee felt that the suggestion was certainly valid and recommends that studies be made toward the end of implementing the Grievance Committee's suggestion.

(Secretary's Note: Discussion of the above section brought out the fact that this action is not mandatory, in answer to questions as to the financial feasibility of implementing such proposals.)

Final Report of the Reference Committee on Constitution, By-Laws and Credentials

Chairman C. C. Wiley submitted the following report, which was adopted section by section and as a whole, without dissent:

The last paragraph of the supplemental report of the Grievance Committee (Board of Supervisors) presented at your Wednesday meeting was referred to this committee. In that paragraph they suggested that the By-Laws be changed so there would always be two members of that Board from Denver. The suggestion was made because of the very nature of the Board's work the Denver member must serve as Secretary of the Board and this plan was proposed so that a new member would always be in the process of understudying an outgoing Secretary.

The Committee on Constitution, By-Laws and Credentials reminds the House again as was pointed out yesterday that such a change would require maior amendment of both the Constitution and By-Laws and would have to lie on the table for a whole year. Discussion with Delegates from outside of Denver has indicated also

that there might be definite objection to this plan since it would change the whole concept of the board including twelve members, no two of them from one component society and with the member of the component society involved in the complaint always excusing himself from the decision. If the proposal were carried out there would be many occasions where at the most only ten members could serve if all twelve were present.

Your Committee on Constitution, By-Laws and Credentials has found what we believe to be a satisfactory method of solving this problem of breaking in a new Secretary for the Grievance Committee without amendment of either the Constitution or the By-Laws. The society has two large and well organized component societies immediately adjoining Denver; namely, the Arapahoe County Medical Society and the Clear Creek Valley Medical Society. There is even the likelihood that as the suburban growth continues, Adams County may again organize its own county medical society and detach itself from the Denver Medical Society.

As the Constitution of the society now reads, the Board of Supervisors (which will be known as the Grievance Committee after adjournment of this session) must consist of twelve members, no two of them from the same component society. The society has twenty-six component societies from which the House may choose those twelve members, six each year for two-year terms. By custom born of necessity, one member has always been elected from Denver. Your Committee therefore recommends that the House at this time not only recognize that custom, but establish an additional one by directing the Nominating Committee effective next year always to choose one member of our Grievance Committee from one of the component societies next adjoining Denver geographically. If this is done effective next year, the member elected from any one of the towns such as Englewood, Littleton, Aurora, Lakewood, Edgewater, Wheatridge, etc., will overlap the term of the Denver member by one year and will be close enough to the society's central office to understudy the board's secretary and serve as the Secretary in alternate years if the board so chooses. We recommend that this be done by Standing Rule of the House of Delegates to read as follows:

"The Nominating Committee shall nominate a candidate for the Grievance Committee from the Denver Medical Society in each even-numbered calendare year and a member from a component society immediately adjoining the Denver Medical Society in each odd-numbered year."

The above Standing Rule was adopted.

This completed the reports of all Reference Committees. There was no unfinished business and no Delegate offered new business.

Upon determining that the Secretary's desk was clear, Speaker Condon declared the House of Delegates adjourned at 9:20 a.m., sine die.

The foregoing abstract of Minutes of the 86th Annual Session is respectfully submitted to the Society.

HARVEY T. SETHMAN,
Secretary, House of Delegates.

News Briefs

COLORADO A.M.W.A.

A State Chapter of the American Medical Women's Association was organized in Colorado in May, 1956 with 23 Charter Members. One of its purposes is to assist young women in medical school and during their internships and residencies.

A Florence Sabin Junior Branch for women medical students was also started at the University of Colorado Medical School.

In September, a supper meeting was held to honor the 23 women students at the School of Medicine.

Mildred Doster, M.D., of Denver, is the first president of the organization.

Component Societies

ARAPAHOE COUNTY

On Tuesday evening, September 26, 1956, the Arapahoe County Medical Society held its regular monthly meeting at the Wolhurst Saddle Club.

The meeting, which was well attended, had as its principal speaker, George W. Holt, M.D., Denver neurologist. He discussed the most recent methods of diagnosing and treating cerebral vascular accidents.

One of the highlights of the evening was the unanimous congratulations given one of the society's own members, Gatewood C. Milligan, M.D., of Englewood, upon his election as President-elect of the Colorado State Medical Society.

Commendation was also given to the orthopedic members of the Society upon their motion made at the Blue Shield Fee Schedule Advisory Committee meeting, lowering fees on selected orthopedic procedures.

LARIMER COUNTY

A dinner meeting of the Larimer County Medical Society was held in Fort Collins on October 3. Dr. Walter Boyd of Greeley reported on the Third National Cancer Conference which was held in Detroit. The next meeting of the society will be November 7 in Berthoud at which time Dr. Bernard T. Daniels, Trustee and Dr. George R. Buck, President of the State Society, will be guests.

—William S. Abbey, Secretary.

Obituary

CHARLES ALBIN BUNDSEN

Dr. Bundsen died September 3, 1956, in the Swedish Hospital where he had been a patient for over a year. He was born October 4, 1872, in Gottenburg, Sweden, and attended college there. He came to this country and graduated from Gross Medical College, after which he returned to Europe to do graduate work in medicine.

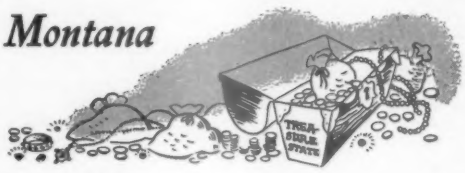
Dr. Bundsen founded the Swedish Sanatorium in 1905 and served it as medical director until 1948. One of his last public functions was taking part in laying the corner stone for the new Charles Albin Bundsen addition at the Sanatorium in 1952.

He was a member of the Colorado State Medical Society, the American Medical Association, the National Tuberculosis Society, the American

Trudeau Society. He was made a Knight of the Royal Order of Vasa, first class, by the late King Gustav V of Sweden.

The only survivor is his widow, Eva, of 2040 Eudora Street.

Montana



News Briefs

PHYSICIAN NEEDED

The Fromberg Lions Club and the Volunteer Firemen have expressed an interest in securing a young physician to locate in Clarks Fork Valley in South Central Montana. At the present time there is no medical coverage for this area which includes 1,200 families. A physician's office is available rent-free, and can be tailored to meet his needs. Any physician who is interested should contact the Lions Club, Fromberg, Montana.

New Mexico

Obituary

JAMES ROBERT SCOTT

James Robert Scott, M.D., 70, Public Health Officer of the State of New Mexico for thirty-five years, died in St. Vincent's Hospital in Santa Fe, New Mexico, on September 14, 1956.

Dr. Scott was born in Hamden, New York, April 29, 1886, and was graduated from the University of California with an A.B. degree in 1908 and was graduated from Cooper Medical College (now Stanford University Medical School) in 1912. He obtained his Doctor of Philosophy degree from George Washington University in 1916.

During Dr. Scott's tenure as a doctor, he served as the anatomist and microscopist for the Army Medical Museum in Washington, D. C. Pathologist for the Los Angeles County Hospital in California and Baker Clinic in Baker City, Oregon. He served as an Associate Professor of Pathology and Bacteriology at the University of South Dakota and as the Associate Professor of Health Education at the University of New Mexico.

He came to New Mexico in 1923 as a County Health Officer in Albuquerque and was later promoted to District Health Officer and in 1940 to Director, New Mexico Department of Public Health, which position he held until 1953. In 1953, he was District Health Officer for Dona Ana County until his retirement in July of 1956 when he returned to Santa Fe, New Mexico, to establish permanent residence.

Dr. Scott was a genial, enthusiastic friend of medicine and his many achievements to organized medicine are too numerous to detail. He and his achievements will be missed but never forgotten.

Obituary

WYOMING'S SENIOR PHYSICIAN DIES

George Palmer Johnston, M.D., holder of Wyoming Board of Medical Examiners' License No. 1, died September 18, 1956, at the age of 93. Typical of Dr. Johnston's energetic approach to living was the fact that though handicapped by failing sight in the last few years, he never officially retired from the practice of medicine.

A native of Greene County, Ohio, he completed his medical course at the Medical College of Ohio in Cincinnati in 1891, coming to Cheyenne in 1892. His office was open to his patients at three different locations on Carey Avenue (formerly Ferguson Street) for a period of 64 years. He with Dr. Samuel B. Miller of Laramie and Dr. M. C. Barkwell of Cheyenne, helped organize the Wyoming Medical Licensing Board which began to function in 1899. Up to 1899 licensing consisted of registering one's diploma with the county clerk of the county in which he practiced. How a troop of "migrating quacks" impressed members of the Legislature with the necessity of passing a more stringent law, is a story in itself.

Dr. Johnston stated that in the early days, scarlet fever, diphtheria and the "grippe" were rampant almost every year. Typhoid fever was common and also confused with Rocky Mountain Spotted Fever until Dr. H. T. Ricketts of the Montana State Board of Health clarified the relationship of ticks and the latter.

Dr. Johnston served on the Cheyenne City Council during a severe typhoid epidemic in 1900 and because of his observation that private wells were associated with the most troublesome areas, worked hard for the development of the city's water system which came into being within a very few years.

From 1906 until the opening of the Laramie County Memorial Hospital in 1923, Dr. Johnston operated the Cheyenne Private Hospital. He was first in partnership with Dr. W. A. Burgess and then later with Dr. J. D. Shingle (1908-1922).

Dr. Johnston served longer in the American Medical Association House of Delegates than any other physician representing a medical association. He was an Honorary Member of the Wyoming State Medical Society.

Dr. Johnston is survived by his wife, two sons and several grandchildren.

Miss Lola Homsher, State Archivist, made recording of some interviews with Dr. Johnston in 1953. These records will be valuable for future reference. Dr. Johnston will be missed, but as he would have it, modern medicine marches on.

UTAH STATE MEDICAL ASSOCIATION

HOUSE OF DELEGATES ANNUAL MEETING

SEPTEMBER 5, 1956

The sixtieth annual meeting of the House of Delegates of the Utah State Medical Association was called to order at 9:00 a.m. September 5, 1956, by President R. O. Porter, M.D., and the following proceedings were had:

President Porter: When I came in the lobby, a person unknown to me handed me this. I think he is a member of the Utah Ministerial Association, and I think it is worth reading.

"May the Lord give you wisdom
May the Lord enhance your knowledge
May the Lord fill your hearts with compassion, mercy and understanding
May the Lord keep you humble
May the Lord keep you well to carry on your mission of mending men's spirits and bodies
May the Lord be your guide."

I think that is indicative of the interest that is being taken in the affairs of medicine in this state, and I should like that to be our invocation, our guiding thought during the day, and our benediction.

The minutes of the 1955 session of the House of Delegates were approved as published in the Rocky Mountain Medical Journal.

Report of the President

President Porter: At the conclusion of my tenure of office as President of the Utah State Medical Association, I herewith submit a brief report of my stewardship.

May I say at the outset that the demands upon the time and energy of the President who takes his appointment seriously and attempts to satisfy his conscience are unbelievably great and are becoming more so as society becomes more complex and socialistic.

We are dealing not with members of a union who accept largely the decisions of their leaders and stop work en masse to enforce their demands, but with highly specialized individuals whose code of ethics and devotion to their profession demands them to continue even in the face of injustice. We are dealing with men and women who cherish freedom of thought and independence, who find it difficult to agree among themselves even when confronted with situations fraught with peril to the profession. We would not have it otherwise lest we lose more than we gain, lest we win the battle only to lose the war.

For these reasons our objectives must be long-range and the solution of our serious problems accomplished through continuous and unrelenting consultations, understandings and friendly persuasion. These statements may sound to some like meaningless generalities, but they are not. They are the core of the weapons with which we are now fighting a battle for the preservation and re-establishment of the free practice of medicine.

Doctor-Hospital Relations

At the House of Delegates meeting a year ago a resolution relative to doctor-hospital relationship was presented. This resolution was referred for study to a special committee to collaborate with the State Medical Education and Hospital Committee and to present a resolution embodying the broad principles governing the practice of medicine in and by hospitals and other corporations in Utah.

Accordingly, on December 14, the House of Delegates in special session adopted such a resolution, which was presented to the Utah Hospital Association and the Presiding Bishopric of the L.D.S. Church. In part the resolution was accepted by both groups, and part of the resolution was rejected as not having been adopted by the American Hospital Association.

We believe considerable progress has been made in arriving at a better understanding of each other's problems and points of view, but until a definition of such terms as "exploitation," "interference with private practice," "corporate practice of medicine," etc., are definitely made and accepted by both parties, there can be no solution. That definition may have to com through the courts of Utah, for one Utah hospit administrator, referring to Dr. Wm. Sproul's lecture in Salt Lake to the Utah Section of the American Academy of General Practice, said in April, 1956:

> "Frankly, in my opinion, Lederle Laboratories who sponsored this speaker, and any others responsible for his appearance, have rendered a disservice to the physicians of Utah and to the hospital whose facilities they used in their practice."

Dr. Sproul, who as I understand it, is the Vice President of the American Academy of General Practice, spoke on corporations and the practice of medicine and the Iowa court ruling. I see no reason for calling that a disservice.

Another administrator of a Utah hospital wrote as late as July 31, 1956, and I quote:

> "Medicine is practiced in and not by hospitals. This hospital does not, nor never will even pretend to practice medicine. Even should the hospital collect the fee and remit to the doctor, this would be done under actual or applied assignment."

A doctor applied for hospital staff privileges. The hospital agreed to grant them if he would accept one of the following proposals:

1. Salary.
2. Percentage of his fees.
3. Fee per case, paid by the hospital which would collect a larger fee from patient.
4. Rental or use fee. No large amount of expensive equipment is involved. In fact, the doctor agreed to furnish his own equipment.

The proposal of the doctor of a fee for service was unacceptable and cause for denying him hospital staff privileges. I submit, is there a better example of fee splitting and corporate practice of medicine?

This administrator believes that if the doctor performs the service to the patient, he and not the hospital is practicing medicine even though the hospital pays him a salary or collects the fee and pays him a portion of it, the Attorney General's ruling notwithstanding. Iowa and other courts have ruled differently and it will probably be up to Utah courts to settle the issue for these two administrators, who are honorable, responsible gentlemen, who must be speaking the language of their superiors. A friendly suit for clarification should be welcomed by both parties.

Permanent Committee Proposed

In order to cooperate fully with the hospitals

and the Utah State Hospital Association for consideration and if possible amicable solution of continuously arising problems, I have proposed to the Council the creation of a permanent doctor-hospital relations committee composed of the Past President to serve for one year, the President to serve for two years, the President-elect to serve for three years, and three other members selected by the Council, one to serve one year, one to serve two years, and one to serve three years. Each year the Past President and one other member goes off, and the President-elect and one other member appointed by the Council goes on the committee for a three-year term. This will give permanency and continuity which is necessary for such a committee.

The Council unanimously adopted the proposal and appointed Dr J. Russell Smith of Provo for one year, Dr. Drew Peterson of Ogden for two years, and Dr. Kenneth Castleton of Salt Lake City for three years.

The second large assignment handed to me one year ago was the task of carrying the ball for Utah medicine in fighting the passage in the last session of Congress of the politically inspired, vote-buying Social Security amendments of 1955. It was difficult because it put us in the light of opposing Social Security, which was never the case. We fought for a realistic bill drawn after a thorough objective study of the needs for more coverage, and one actuarily sound and one that would encourage rather than destroy rehabilitation and incentive.

I was called twice to Chicago on this matter and was asked to present Utah's case for medicine to the Senate Finance Committee in Washington; and on invitation, met with five county societies in Utah, one in Idaho, and San Bernardino County Society in California on this legislation.

The majority of the Senate Finance Committee was convinced it was a bad bill and risked their political necks by reporting it out unfavorably, with the objectionable features deleted. On the floor of the Senate, however, we lost by a vote of 45 to 47. One more effort in the right spot would have saved the day. That wasn't our Utahans; our Senators Bennett and Watkins voted against it. Now all we can say is, God help us in the years to come! We are again face to face with the ghost of socialized medicine.

Public Relations

We have been active in the past year in the program of public relations begun the previous year. Meetings have been held by the Executive Committee and members of the Council and some committee members with representatives of labor, labor unions, industry, health insurance plans, etc. These meetings have but one aim and can have but one result, better understanding of each other's problems and a friendlier atmosphere.

There has grown up the practice of the Utah State Medical Association honoring one laymen each year for his contribution to and interest in some phase or phases of medicine. As Topsy just growed, so did this practice. Until now, the selection of the recipient of this award has been made by the Council and the award has been made at a small dinner meeting of the Executive Committee and a few distinguished guests.

We feel as if this is excellent public relations and the selections have been good. Two years ago, the recipient was William Patrick, our good press friend; last year our selection was His Excellency, Governor Lee; and this year the old work horse for medicine, Otto Wiesley. However, we think there should be more representative participation in the selection of the recipient and in the presentation of the award, and therefore recommend that the House of Delegates make the selection and award the citation. That will be taken care of, I think, in the amended Constitution.

Last year the Utah State Medical Association through the State Department of Health, requested the U. S. Public Health Service to study the current industrial health resources of Utah.

1. To determine the existing medical and nursing resources in industrial health.
2. To analyze the contributions that existing public health programs can make to the advancement of industrial health.
3. To survey a representative group of industries to determine their problems and needs.
4. To devise a plan for coordinating the communities' health resources in the best interest of industrial health.

This survey was made during September and October, 1955, and a voluminous report of 32 pages was delivered to us last February. In April we met with representatives of the Public Health Service and they explained the report in detail. It is a startling revelation of deficiencies in meeting the industrial health needs in Utah. It is a challenge to the Utah State Medical Association and the State Department of Health to activate a long range program to overcome some of these deficiencies even if it requires legislative enactment to do so.

New Member Indoctrination

One of the objectives outlined and announced for this year's work was the establishment of an indoctrination course for beginning practitioners in Utah. An outline for one full day's instruction was worked out by the faculty of the Medical School in collaboration with the Council, our legal advisors, and was scheduled to be given the day preceding the House of Delegates meeting, which would have been yesterday. This was approved by the Council, but two considerations prompted us to postpone inaugurating the program until next year. The first was that Salt Lake County Society gave a somewhat similar instruction course for new doctors joining that society. The second consideration was that there should be some way of requiring attendance.

In my opinion, this should be a state and not a county activity so that all new doctors would be brought into it. I am therefore offering a resolution relative to this subject which I hope will receive your approval.

While the Constitution and By-Laws delegates authority to the President and Council to delete useless committees and create new committees considered desirable, there are two new committees I am proposing which I consider of sufficient importance to warrant approval by the House of Delegates. One is the permanent Doctor-Hospital Relations Committee I referred to earlier, and the other is an Adoption Committee which also should have some permanency and continuity. This latter committee has been requested by the Children's Service Society of Utah, who assure me of statewide support from adopting agencies and especially the adopting parent groups. Since I am twice a grandfather to the product of this organization, I assure you I am enthused about the creation of such a committee.

In conclusion, I want to thank you again for bestowing this high honor upon me and I hop I have in some small measure merited your confidence. I want to thank the committee, many of which have done a splendid job and get little recognition. I want to thank the Executive Com-

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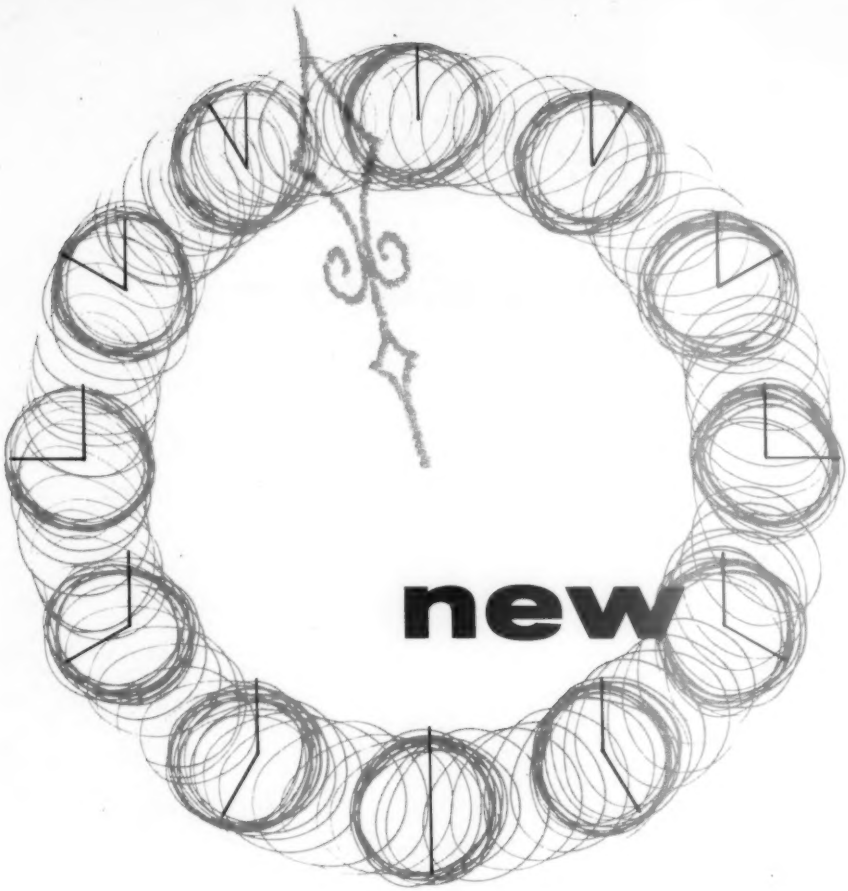

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mittee and the Council for the support and help they have given me, without which little could be accomplished. My thanks to the Executive Secretary, who is always in the middle and has been most helpful, to Dr. Donald Moore, our Secretary, who is largely responsible for the fine scientific program which is to follow, and to our efficient and helpful Treasurer, Allen Macfarlane. My thanks to Charlie Ruggeri, whose interest, like the old soldier's, never dies; and finally, I ask for a continuation of this fine support for my successor, Dr. James Z. Davis, who is fully equipped to both give the signals and carry the ball.

Mr. Bowman: Gentlemen, do I hear a motion that the President's report be approved?

The motion was made, seconded and approved.

Dr. Ray T. Woolsey: I shall present a resolution now for consideration this afternoon, that the matter of the question of the relationship of the Utah State Medical Association and the Children's Service Society, regarding the question of the adoption of children, be rescinded and that we vote on it at a subsequent session of the meeting.

The motion was seconded and defeated.

President Porter: The next order of business is the report of the Woman's Auxiliary by Mrs. Eddington of Lehi, President of the Woman's Auxiliary this year.

Mrs. Elmo Eddington: I deem it an honor to be asked to give a brief report at this time. I know your time is very valuable and budgeted to the last minute.

I have been a member of the Auxiliary to the Utah State Medical Association for twenty years and I recommend it most highly. It is valuable from a social aspect and also from the point of accomplishing things. We have many things we undertake, many projects we feel are of value and well worth the time of your wives.

Our outline, if you don't know just what we have by way of organization, follows the pattern of the National Auxiliary and we have committees on Civil Defense, Archives and Biography, which is my love, and the Benevolent Memorial Fund, which is a fund that we have developed; Finance and Budget, of course, Legislation, Mental Health, Nurse Recruitment, Press and Publicity Program, Public Relations, and Today's Health. We of course still have Today's Health magazine more or less as our baby.

Last year I might say that in the interest of community service and philanthropic work we spent more than a thousand dollars; and this of course was all raised by our own efforts. We do not use our dues for this sort of thing. We also spent $1,020 in Nurse Recruitment, which fund also was raised by our own efforts. We had rummage sales and cake sales; and if you missed your last winter's topcoat, you might see it walking down Main Street. In that case, you would know it had gone toward the cause of Nurse Recruitment. Last year we stressed very much the encouragement of Registered Nurses to go on in a specialized field, particularly psychiatric fields, as a specialty.

The Benevolent Memorial Fund gave three $100 gifts to senior medical students, and that was well received.

Our Legislation Committee was headed last year by Mrs. Lloyd L. Cullimore, who was a former member of the Utah State Legislature. Of course, she was very capable and gave us a great deal of information regarding the bills of interest, and of course this year that will be pursued very carefully.

The Mental Health Committee worked very strenuously last year. In Carbon County there was a great deal of activity. They are incorporating, I think, a clinic there. And of course in Utah County, that is our great interest.

President Porter: Did you pursue the aid to the medical school program that the national organization has?

Mrs. Eddington: The A.M.E.F.? We did not for this reason: One or two of the auxiliaries had fund raising projects which netted around $75, but we do not because our husbands pay a set amount, and we figure inasmuch as they pay our dues we would kind of claim that.

Report of the A.M.A. Delegate

Dr. George M. Fister: Again let me express my appreciation to you for the honor of representing our State Association at the meeting of the House of Delegates of the American Medical Association. I also want to reaffirm my conviction that the problems confronting organized medicine in Utah and in our country are being seriously studied, and that time will substantiate in general the discussions and conclusions of our Association.

With the ever-changing economic conditions and geographical distribution of our population, there results many serious problems for our profession. Your elected representatives are requested to spend many hours in investigation, study, and in committee meetings in an effort to protect the health of the people and the honor of our profession. But the final solution, the final level of public opinion, and the continuation of private enterprise (practice) rests with the activities of each member of our Association.

(Dr. Fister then reviewed actions of the A.M.A. House of Delegates in detail.)

Now, permit me to congratulate our President, Dr. Porter, for his progressive and considerate policy in the interest of the medical profession of this state and nation. He has worked hard and faithfully. The success of his policy has been the result of an especially faithful group of officers, committee members, and a conscientious, ever on the job, Executive Secretary, Mr. Bowman. To them I express the thanks of the 150,000 members of the American Medical Association. The Woman's Auxiliary of the Utah State Medical Association is a most outstanding organization. Their leadership for the betterment of humanity and the dignity of the medical profession is a remarkable achievement.

Dr. L. B. White: One question please. I notice that in our budget, about 12½ per cent of our total dues is allocated to the American Medical Education Foundation. When you compare what Illinois gave with what Utah gave, it figures out about ten times what we gave. They are certainly ten times bigger. The thing I have been wondering, we have included this as a "must" in our dues, it is compulsory that we pay it, whereas these other states are probably doing it on a voluntary basis. I would like to ask that question before we approve the budget.

Dr. Fister: I think you can answer it better than I can. The Utah House of Delegates did vote last year for a dues increase in the amount of money that goes to the A.M.E.F.

President Porter: We voted a dues increase of $20 per member to go to this fund, and from that we raised $11,500.00 which was the reason for this citation. It is signed by the President, Vice President and the Secretary-Treasurer. We went back there and made our voices heard in favor of either raising compulsory dues throughout the whole country, as we had done and many other states have done, or find some other way of financing medical education. Actually, I was almost opposed when I went back

to the continuation of the compulsory $20 assessment. But we find many other states are doing the same, and as a result of that more states are constantly coming in. Some of the states absolutely refused because they consider it an infringement upon their free life; they shouldn't be taxed. Of course they shouldn't be taxed for anything, but they are taxed.

Medical education is really at the crossroads right now and as a result of that, we are not able to produce the number of students necessary to take up the losses that we have each year and to take care of the increasing population.

And in yesterday's Tribune is this headline: "Aliens Glut Hospital Staffs, Doctor's Survey Asserts." It shows at least 25 per cent of the residents in the hospitals are alien doctors, doctors who have had their medical education in some other country which may be substandard from our point of view. That is the reason I asked the President of the Auxiliary if they had taken any action on this fund raising for medical education. They didn't, largely for the reason she mentioned: that we were contributing $20 apiece. Many other states are not doing that. In fact, in some instances I suppose if you took an average of the number of men belonging to the society, it would amount to two or three dollars instead of $20.

But more state organizations are coming to the raising of funds by increasing the dues; and I came away quite convinced that it was the only way we are going to preserve our type of medical education and increase the facilities.

Dr. Ray T. Woolsey: Talking about the question of graduates of foreign schools, I don't know whether you happened to read "Scope" last week, but it was reported in Scope that 6,053 graduates of non-American schools served residencies and internships in American hospitals last year. That is about 700 more than there were American graduates in the hospitals at the same time.

President Porter: There is also one other rather interesting thing in that connection. Some American boys are going to foreign countries for medical education because they can get it cheaper and it isn't as hard to get. I think it is a problem we must face in some way or another. As a matter of fact, it is necessary for this foundation to raise $10,000,000.00 this year and that is a lot of money. I think Utah certainly is outstanding.

Dr. Porter: I should like to introduce Dr. Phillip B. Price, Dean of the University of Utah College of Medicine.

Dr. Price: I received an invitation to appear here to answer any questions that might arise, particularly in regard to the meeting between a joint committee with representatives from the University on the one hand and of the State Medical Association on the other. Some of us were members of both.

This committee has met and has discussed the proposition. I am sorry that we haven't had a more recent meeting, although actually there isn't much to report to that group of recent developments. However, there is a report in your hands which comes from the committee of the State Medical Association in regard to the proposed new Medical Center.

Perhaps I might state as briefly and as simply as I can the reasons that I see why the College of Medicine and the state need new physical facilities. I think there are six cogent reasons.

The first is that the College of Medicine can work more efficiently and effectively with adequate facilities. I think that is self-evident. I can drive better in a modern car than I can in an ancient jalopy. We can live better in our homes than we can in cabins. You can carry that through our whole modern life in every phase.

The second cogent reason is that a new Medical Center is needed if we are going to keep our present full-time faculty. The faculty came here—most of them are not natives of Utah—in the hope that we would get new facilities and a new Medical Center. This thing has been talked about since 1943. It has been a hope deferred for all these years, and some of them are getting pretty discouraged. Many of them are receiving offers to go elsewhere where there are far better facilities and indeed much better salaries; and it has been this hope that has kept many of them here.

A third reason is that better facilities are needed if we are going to attract suitable new members to our staff. As you know, we have had certain vacancies there, and we have had numerous candidates who have come to fill those vacancies. I believe it would be worth the three or four minutes to read you some excerpts from letters of candidates who have visited here, spent several days looking over the situation, and then have declined or withdrawn their application. This is from one:

"I have given the situation at the University of Utah considerable thought, and also have attempted to analyze critically my feelings concerning my position. At Utah, I was very impressed with the staff. This was no surprise to me because of the productivity of your University over the years. I was considerably impressed with the tremendous job that has been done by the staff with the very real handicap of inadequate physical facilities. Perhaps, this more than anything else, has discouraged my interest in the position available.

"For this sentiment to be understandable, one must be backgrounded in my own experience over the past seven years. Prior to accepting my position, it was a foregone conclusion that a University Medical Center would be built and functioning within two and one-half years. The vagaries of the State Legislature and circumstances have delayed this goal up to the present time. Meanwhile, all of us here have spent innumerable hours in planning, redoing plans as money appeared available, then unavailable, and finally inadequate. Ground is being broken now for a center the size of which is unknown until the Legislature meets in 1957. In all honesty, I must admit that this has been an exceedingly difficult period and better avoided in the future if possible.

"Obviously there are many items in any medical school setup on both the positive and negative sides of the ledger, which might be developed; however, the lack of a proper working facility more than anything else has influenced my decision. While I have great confidence in your ability to effect the final development of a University Medical Center at Utah, from past experience it is a period of severe harassment; yet I am certain that it will come."

Here is another one:

"My reason for refusal was that I had a few serious reservations in my mind that may turn out to be unfounded.

"One major question in my mind is the extent to which the community is really behind the medical school. I feel that the faculty at Utah has made it a very strong school, but I gather this has been done to a great extent on outside grants and in the past there has not been the local financial backing that would be desirable. I realize that you all have high expectations of getting a new Medical School and I share your hopes. This seems a critical issue to me for I do not think the school can realize its potentialities unless it has strong local support. If the building appropriation by the state does go through I think you will be in a much stronger position to attract people to the Medical School. I do not question your judgment of the likelihood that this will go through, but as an outsider I must be impressed by the fact that you have had an outstanding school for over a decade and the building is long overdue. The big reservation in my mind was this: If

I had come to Utah and due to unexpected political developments the appropriation for the new school did not come through, then I would have felt that I had made a serious mistake."

And one more, if I may:

"After very careful consideration that in view of my uncertainty about certain aspects of the position there in Utah I would be wise not to make the move from my satisfactory and at least partially academic position here. I am very reluctant indeed to become a member of a State University. This concern seems justified in view of the reluctance of the Legislature or Board of Regents to provide a superb faculty with an adequate physical plant for ten years, in spite of precedents established in most other states. This may sound foolish to you who have found a happy life there, but it is my own personal feeling. I am also concerned about the plan to build only a 250-bed hospital and was distressed to learn that the President had no idea of advocating any more than that. I am convinced that the optimum situation for a Medical School is to have all of the teaching facilities that are necessary for training in the University Hospital, although I realize that this is not always possible."

New facilities are also needed if we are going to attract interns and residents of high caliber.

A fourth cogent reason it seems to me is that Utah is at present at a disadvantage in attracting good medical students. I happened to have been the Chairman of the Admissions Committee for the past several years, passing that chore onto somebody else this year. A few years ago nearly all of the good students that we accepted came to Utah. Now an increasingly large proportion of them are going elsewhere. This is true not only of Utah students, and some of your own sons have elected to go to other schools with better facilities than we have here, but this is also true of neighboring states.

You may know that recently an organization has been set up which is called the Western Interstate Commission on Higher Education, by which arrangement, if Utah has a dental student and we don't have a dental school, we send him to a school in one of the neighboring states and Utah will subsidize that student. On the other hand, if Arizona or New Mexico or Nevada or Idaho has a medical student and they have no medical school, they will send him to a medical school within this area of thirteen western states and Alaska and Hawaii, and the state concerned will subsidize that student if he is approved. Now we are beginning to lose out on this program simply because we have such poor facilities that the students elect to go to Colorado or California or some other state.

In addition, I have heard only during the past week that Arizona and New Mexico are considering building their own medical schools, possibly only two-year schools, possibly four-year schools. And I think one very real reason for that is that when we are visited by people from those states, either teachers or prospective students, we show up very poorly.

Another cogent reason is that competition from other states has become so great that we are in a very unfavorable position. There are at present nine states in the Unted States that are building medical centers and Utah is the last state in the United States with a medical school to provide adequate facilities. I don't know of a single other one—even poor states like Georgia or Mississippi or Arkansas are able to build and are building medical centers.

I have been criticized for using the word "modest" in connection with our plans. Modest, of course, is a relative term; and in comparison with the medical centers in other parts of the United States, ours is modest in that it is the lowest estimate of any of the centers that I have been able to find out about. This is not simply a matter of state pride. This is a matter of competition; and it is useless and unrealistic for

us to say that we will not care what other states do. We are competing with them for faculty, for students, and for interns and residents.

My final reason is that Utah has made good progress so far in spite of difficulties. It has the opportunity if given facilities, to step out still further in leadership, not only scientifically but in medical education as well; but I do not believe it can be done if we are not given adequate facilities to work with.

President Porter: If there are any questions you would like to ask Dr. Price, let us have them.

Dr. Ray T. Woolsey: This development of this medical center, then, is the differentiation between the three and a half or four million dollars that the committee talked about up at the Holy Cross Hospital, and the eight to ten million dollars that the Board of Regents published in the paper as the cost of the medical center; is that the situation? I can't quite get the sudden increase in the amount of money needed, when at the meeting of the County Society you talked in terms of three and a half or four million dollars, and when the Board of Regents meets, it was published in the paper that they are talking in terms of eight to ten million dollars.

Dr. Price: It is not easy to separate the cost in an integrated building of this sort. But if one takes that arbitrary limits, the figure that has come out at present is approximately $4,500,000 for the medical school, together with the research facilities and all the things that go into the medical school, and approximately $4,300,000, or something like that, for the hospital, outpatien department rehabilitation center and all its ancillary services. This is a figure that has been talked about at least for the past fifteen months, and I am not quite clear what was referred to when you were talking about the $3,500,000.

Dr. Woolsey: At your meeting at the Holy Cross Hospital before the Salt Lake County Medical Society, you and the committee representing the faculty said the hospital would cost $3,500,000; and in the newspaper they came out about the hospital costing eight to ten million dollars. That is the point I am getting at.

Dr. Price: The hospital wouldn't come to that; the hospital would cost at present estimates something between four and four and a half million. Building costs are rising everywhere this past year. The architects tell us the daily rates of labor have gone up so much, and they have raised their estimates from $20 a square foot to $22 a square foot within the past few months.

Dr. Snow: One of the questions that comes to the minds of most of us is, where will the patients come from to fill a hospital like this? I understand that there is a dearth of surgical material at the County Hospital at the moment and has been for some time. If they build another hospital on top of it, where will the material come from? And is it to be entirely cared for by the full-time staff, or will the part-time faculty have any obligations to the hospital or patients in the hospital entirely aside from the cost of the hospital? I don't think there is any question in the minds of most of us of the desirability of a new medical facility. But most of our worries come from the development of a super medical organization at Ft. Douglas which will be an attraction to patients and a wedge for the opening of socialized medicine. There are a good many things that come to our mind that bring us dread of an organization like that; and we want to be sure that those things won't occur and that we will be allowed to bring patients to the hospital and take care of them.

Dr. Price: That is a very pertinent question,

and is one that we have been greatly concerned with. It is quite obvious, especially to those of us who have lived and worked in this community for many years, that there probably is not need or room at the present time for an extra hospital if the County Hospital is going to carry on as it is at present functioning. Our problem is not a super structure, but rather a transfer of much of the present County Hospital activities to a University Hospital, this for two reasons: One is that we need it as a part of a medical center, and that I have already dwelled on. The second is that the facilities at the County Hospital are so poor that new structures would have to be built there in the near future if it is going to continue as a hospital. Why put a large amount of money, perhaps an equal amount, several million dollars at any rate, into building new structures there if there is an opportunity to put that money more effectively in a University Hospital?

At present there are 249 beds in the County Hospital. Those are housed in nine antiquated buildings, built approximately fifty years ago except some temporary structures, such as the old ITC Center which was built during the war with a ten-year life expectancy. It has already gone now more than ten years and it is falling to pieces. Of nine structures, there are only two that are substantial enough to be considered at all permanent. The other seven are going to have to be scrapped in the near future. The County Commissioners are very much concerned about this. Our proposal is not that we add a hospital and look around for some extra private patients somewhere, but we have a University Hospital with 200 beds; that the County Hospital be converted to what is greatly needed in this community and give us better facilities for patients who need institutional care but who do not really need the expensive care such as a hospital provides. Many of these patients are now unhappily situated, housed in nursing homes. We don't want to run into competition with the nursing homes either, but there are not enough nursing homes to take care of the needs; and there are many patients there who need medical care who are not able to receive it.

Our proposal is therefore that the present activities of the County Hospital be transferred to better quarters and that the county be asked to pay on a pro rata basis no more than they are paying now, in fact, less than they are paying now; and that the University Hospital also be made available to other counties of the state, if those counties so desire—that would be entirely voluntary on their part.

The reason why we are suggesting a 200-bed hospital whereas the county has 250 beds is that with the present inefficient arrangement, our bed capacity can't run more than about 160 to 170 patients. In the new hospital with say 80, 85 or 90 per cent bed occupancy of 200 beds, that would give us our 160, 175 beds. I don't believe that we could have less than that and be accredited as a Medical School.

The County Hospital then if it would expand its present infirmary and we cut down the infirmary, please remember, from something like 200 beds in years past to about 120 beds at the present time—if that would be expanded back to 200 beds in of course the good permanent buildings there, the medical staff of the school, the full-time medical staff, with your help if you so desire, will undertake the professional supervision of those patients down there. We can use that as part of our teaching process; but the acute cases, I would hope, would be in the University Center.

Report of the Secretary

Dr. Donald R. Moore: The Secretary's report is found on Page 43 of the handbook. I will not read it in its entirety. The primary job of the Secretary is to function as Chairman of the Scientific Program Committee. I would like to thank all members of the committee who have helped very much in preparing the program that is to come. We have followed certain principles in preparing the program.

First is the selection of the speakers. We have ten outstanding men who will speak to us in the next few days. The morning sessions will consist of general sessions directed to the general practitioner primarily. The afternoon sessions are directed more to those in specialty groups. The meetings are designed to be of interest to both types of practitioners. The noon-day luncheons will be primarily panel discussions and to answer questions of members in the audience.

The University of Utah College of Medicine was asked to participate freely in the program. The faculty of the University has been very helpful in preparing the program, and they will participate a great deal in panel discussions.

Report of the Treasurer

Dr. Allen P. Macfarlane: On Page 8 of your booklets is a condensed statement from the annual audit. You will see that we received from dues in the year 1955-56 a total of $35,960.50; and we expended in the year 1955-56 $34,814.53. The special assessment for the University of Utah Medical Library is not derived from the general funds of the Association but is taken from the special A.M.E.F. assessment. First is the Utah Health Council. Previously budgeted, $4,000.00; amount expended, $4,000.00; recommended, $4,000.00.

Dr' T. E. Robinson: I move its adoption. (Seconded. Thereupon a vote was taken and Dr. Robinson's motion carried unanimously.)

Dr. Macfarlane: We have given the University of Utah Medical Library $2,000.00 each year for several years. They have requested more, but it is our recommendation that the amount remain at $2,000.00.

Dr. T. E. Robinson: I move its adoption. (Seconded and carried unanimously.)

Dr. Macfarlane: We have previously budgeted for the Woman's Auxiliary $3,180.00. They expended $3,457.50. I am not sure where the difference came from. Can you account for that, Harold?

Mr. Bowman: That is accounted for by the growth in membership each year.

Dr. Macfarlane: We thought it should be open to discussion, whether you feel that the Woman's Auxiliary should get the same handout of $5 from each of our pockets and not have to raise money on their own initiative.

President Porter: It has been moved and seconded that we appropriate the amount expended last year, $3,457.50. (This part of the budget was approved.)

Dr. Macfarlane: The Rocky Mountain Medical Journal is self-explanatory, $2.50 per member. The increase over last year is accounted for by the increase in membership. It is recommended that the same amount be disbursed. (A motion was made, seconded and approved.)

Public relations: $3,500.00 budgeted last year, $1,990.20 spent last year. It is recommended that we budget the same amount for the coming year, particularly in view of the coming legislative session. (Motion was carried.)

Dr. Macfarlane: Travel, $4,500.00 budgeted last year, $4,940.00 spent last year, budget this year

proposed $4,500.00 again. (A motion was made, seconded and approved.) Attorney's Retainer Fee. This is fixed at $75.00 a month. (This was approved.) Office expenses, $16,000.00 budgeted, spent $15,104.00, proposed $17,000.00. (Amount approved.) Miscellaneous Items, $500.00 budgeted last year, $693.00 spent, $500.00 recommended. (Approved.)

Report of the Councilor of Box Elder Medical Society

Dr. W. R. Merrell: Dr. J. Howard Rasmussen is the Councilor from our society, but he is out of the state. His report is on Page 39 of the brochure. We have eleven members in the Box Elder County Medical Society and we just completed a very harmonious first year since our reorganization. Prior to that time, we were members of the Weber County Medical Society.

Report of the Councilor From Carbon County

Dr. L. H. Merrill: You will recall that at the September meeting, one of the members from Carbon County, not in the society, asked that Carbon County be investigated; and you will recall that this House of Delegates voted that that investigation be made of Carbon County. That investigation was made. Carbon County didn't feel it was warranted and so protested; but the Council felt inasmuch as the House of Delegates had passed that resolution, that Carbon County should be investigated. And consequently three members were sent down by the President of the State Medical Association and that investigation was made.

The report of that investigation was never received in writing but I am told by the members that they found everything in order and commented on the high type of medical practice that was being carried on in Carbon County. Whether or not in the future there will be further examinations of the Carbon County situation I do not know. We still have the same situation that prevailed last year and everything seems to be going on harmoniously with the United Mine Workers situation.

With respect to our meetings in Carbon County, we always have a dinner meeting, meet with the Auxiliary for dinner before the regular session of our meeting.

At the time this report was written—it is on Page 38—we were anticipating starting a hospital in Price. Since that time, the hospital has been started. If we had the Church behind us, maybe we could build it like the L.D.S.

Dr. Donald M. Moore: This is a letter from B. K. Wilson, M.D., of the Carbon County Medical Society addressed to Harold Bowman:

"Dear Mr. Bowman:

"Please send enclosed letter through the proper channels for review by the House of Delegates.

"This is from the Carbon County Medical Society. The subject: Crippled Children's Service.

"This letter is presented by the Carbon County Medical Society as a request for review of the function and policies of the Crippled Children's Service in Utah. The basic concept of the Crippled Children's program is to make available through state appropriations the finest of medical and professional service to those children whose financial status is such that they could not receive proper medical attention otherwise. The program has been functioning in our area approximately fifteen years, during which time excellent medical attention has been given many beneficiaries of this program. We feel that the time is right for review of the policies and functions of this program. . . ."

Dr. Ray T. Woolsey: I move a committee be appointed to investigate the situation. It seems to me like it is the same old thing we have had since the government started to get into the

business that the local man is no good; we have to ship the patient to Salt Lake City or some place else to have them taken care of by the four-star specialists. I think it is time that the state association, through appropriate action, make some move to stop this thing and see that the man in the local area at least has a chance to make enough money out of the government to make his taxes back anyway! (Thereupon a vote was taken and Dr. Ray T. Woolsey's motion carried unanimously.)

Report of the Councilor for Southern Utah

Dr. R. G. Williams: I have nothing to add over and above the report which is printed in the handbook.

Report of the Councilor to the Uintah Basin

Dr. T. R. Seager: My report is found on Page 31. I would like to add a few words to it. I have made a list of three items pertaining to the Basin territory which might interest you.

The first is on Indian health. There has been quite a bit of publicity in the paper this last year on the Navajo Indians. Out in the Basin we have mostly the Ute Indians. At the present time they are all on private care. During the past two years the government has closed the hospital there and released them all to the care of private practitioners in the Basin with the exception of a large number of them who are indigent. The cost of their medical care is handled by the Indian Agency, but they are referred to private practitioners either in the Basin or in Salt Lake City. I think that is a good step forward in this problem of Indian care.

The next item is another problem that received quite a bit of publicity during the past couple of months. That was the dysentery outbreak that occurred in mostly Duchesne County, and mostly Roosevelt. I would like to call your attention to that as an awfully good example as to what can happen and will happen more if we don't pay more attention to this water pollution problem.

The last item concerns the problem of probably fairly rapid future development in Eastern Utah, not just Uintah Basin, but also Southeastern Utah, which has been brought to a head by the passage of the Upper Colorado River Utah Project, which will start with two major dams on the river, one on the Colorado and one on the Green River just thirty-five miles from Vernal. These dams along with other work that will go along with them are going to be responsible for a very great industrial development in Eastern Utah in the next few years. This entire area at the present time has more or less of a medical shortage. In our populated centers we have quite a few fairly well qualified doctors who don't have enough to do. Everyone of us in Eastern Utah, both northern and southern, has more than we want to do every day. We would like to elicit your support to encourage some of these fellows to move out in the outlying territory and get a little experience for a few years, like it used to be done. While they are at it, they can line their pocketbooks pretty good, I am sure.

Dr. Ruggeri: I would like to make a verbal report of the trip of the committee appointed by your President on the Carbon County situation. That committee was composed of Dr. Fister, Dr. Davis and myself. I made a trip or two down there to investigate the Carbon County situation and I talked with a lot of doctors individually. Mr. Bowman, our Executive Secretary, Dr. Davis and I—Dr. Fister didn't go that particular day

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when the three of us went down together. We visited the hospital at Dragerton, we visited the hospital at Price, we talked to individual doctors, and we had a meeting of the Carbon County Medical Society at which I think they had probably 99 per cent attendance. As we found the situation, there wasn't anything that I can see that creates any serious problem whatsoever. Medical practice in Carbon County—and I think I can speak with some authority about this because I practiced down there for seventeen years—is better now than it has ever been. They are doing excellent work.

In talking with the gentlemen who presented the resolution at the last meeting of the House of Delegates, and in talking to others who were on the side that were more or less to be considered as complainants, and talking to them privately, the one question that I asked after they had a chance to get everything off their chest, was: "What would you do to better the situation or to make any changes?" And every one of them gave me the same answer, "There is nothing you can do."

I don't see that there is anything that we can do. The situation is not out of hand at all. For the benefit of those who might think that this outfit from California is in there practicing medicine, they are not. They own the hospital and that is about as far as we could determine their responsibility goes. The hospital at Price is owned by the county and the city, and they run it. Both of those hospitals have been accredited. They are keeping good records. They are practicing a high grade type of medicine.

Councilor From Utah County

Dr. R. E. Jorgenson: I want to read a paragraph or two we forgot to add.

Medical problems in Utah County have been the same as the major problems in other areas of the state, only more so. An anesthesiologist tried to locate in our area and do private practice. He wanted to work on a fee for service basis and collect his fees from the patients and have the hospital collect for their services. He has been unable to do this because the hospital administration say they have a monopoly and must be compensated in some way. The problem is unsettled at the time of this report. We are hoping for a solution to the problem.

The Council at their last meeting made some by-laws to this resolution we adopted last December, which does clarify what they meant in addition to this resolution we have here. I presented them to the County Society August 30, and our delegates were instructed to back this action by the Council regarding this matter. We feel that an agreement at the state level between the Medical Association and the Hospital Association or the L.D.S. Hospital System appears to be the only way to answer this problem.

Report of the Councilor of Weber County

Dr. I. Bruce McQuarrie: In our county we are getting success on water purification and sewage disposal. Many doctors have worked with the Chamber of Commerce and the Council. We now have both systems under way. Last year we helped to elect one of our men to the City Council, Dr. John Dixon, and he is doing a very fine piece of work with the council. It has materialized in the city obtaining a health unit, an individual building, and also we will have a full-time health officer and the health office, which I think is very fine. I think all the doctors supported Dr. Dixon and he is doing a good job. With this water purification and sewage disposal, I think maybe we are growing up a little bit in Weber County. Other than this, I can just report that we have had a good and pleasant year in our society.

Report of Reference Committee No. 1

Dr. Wallace S. Brooke: Reference Committee No. 1 reviewed the following assignments: The report of the Councilor of the Salt Lake County Medical Society, the report of the Councilor of the Weber County Medical Society, the Executive Secretary's report, the Councilor from Carbon County Medical Society, the Councilor of the Box Elder County Society, the Councilor of the Utah County Medical Society, the Councilor of the Southern Utah Medical Society, the Councilor of the Central Utah Medical Society, the Board of Professional Relations report, the report of the Rheumatic Fever Committee, the report of the Medical Economics Committee, report of the Newspaper Health Column Committee, report of the Secretary and Chairman of the Scientific Program Committee, the report of Veterans Affairs Committee, and the Legislative Committee report.

Your Reference Committee has gone over the report of the Councilor of the Salt Lake County Medical Society. We would comment that a reference committee, in looking at many of these reports, can do nothing except report that they are adequate, that in some instances they perhaps are incomplete because of things that have happened since they have been turned in and because of other obvious things that are left out; but we do not feel that this reference committee's job is, as perhaps it was three or four years ago, to introduce resolutions. This particular phase would seem to have been taken over by Dr. Snow's Resolutions Committee. I will then simply report what our committee thought of these reports, adding in a few instances some comments.

The Executive Secretary's report is next. Here there are a few things that we would comment upon. Those of us on the committee—Dr. Malouf of Logan, Dr. Millburn of Tooele, Dr. Moody of Spanish Fork, and Dr. Bryner of Salt Lake—felt that our Executive Secretary has done a very splendid job. Those of you who worked with him throughout the last year know that he devotes a lot of time to the job; and I wonder how his wife takes it when he is away at night attending meetings. He mentions the "Standards of Practice Governing Doctors and Lawyers." This has gained national recognition and we thought this was a fine piece of work.

Other things of interest include the contracts reviewed by th emembers in the last year; the significant reduction of malpractice suits; and Mr. Bowman's statement of the increase in membership; it has continued at a normal rate. For instance, in 1952, there were 706 doctors in the state, in 1956, 818, which I suppose represents roughly a change commensurate with population growth of the state.

Report of Reference Committee No. 2

Dr. O. E. Grua: To begin with, the report of the Committee on Constitution and By-Laws. Dr. Smith's committee reports the changes which are incorporated in the new Constitution and By-Laws. The committee feels that this is a good Constitution and that these changes are acceptable; that certainly it behooves every member of the society, and particularly the delegates, to be familiar with the Constitution and By-Laws of this organization.

The report of this committee was accepted.

Report of Reference Committee No. 3

Dr. W. R. Worley: Reference Committee No. 3 met in Salt Lake City on August 30, 1956, to review the following committee reports: Necrology Committee, Cancer Committee, Sewage, Water and Air Pollution Committee; Geriatrics Committee, Tuberculosis and Cardio-Vascular Committee, Utah Health Council Committee, Industrial Health Committee, Insurance Plans Committee, Mental Health Committee and Civil Defense Committee. The reports of these ten committees were reviewed and unanimously approved by Reference Committee No. 3 with the following notations:

In the Cancer Committee report we would like to emphasize their recommendation: "It is recommended that the Cancer Committee be composed of members of the Medical Board of the Cancer Society, as such an arrangement would decrease the number of yearly meetings to be attended by the physicians and would be beneficial to both groups."

On the Insurance Plans Committee report we felt that the report as such was good, but we thought the idea of study for adoption of a standardized insurance form claim blank should be brought in and adopted. We leave this for study and for future reference.

The report of Reference Committee No. 3 was approved.

Report of Reference Committee No. 4

Dr. Roy B. Hammond: Reference Committee No. 4 was assigned to check the report of the Committee on Rural Health, the Medico-Legal Committee report, the School Health Committee report, the report of the Medical Advisory Board of the University of Utah College of Medicine, and the Medical Education and Hospitals Committee report.

The first is the report of the Committee on Rural Health. The committee approved and recommended the adoption of this particular report.

We did want to bring out a point which was brought up in a motion this morning, with respect to this Crippled Children's Clinic, and also perhaps the Rheumatic Fever Clinic and the Child Guidance Clinic, to make sure whether or not they are being run on an entirely equitable basis. It was brought up that perhaps there had been some reports that fees may have been charged and these clinics were not being run in accordance with our ethics as we see it today. We felt this committee next year should look into this. There was a motion passed this morning concerning the Crippled Children's Clinic, and I think it should include all of these.

Secondly, we thought there should be some report on the Indian Health Program. That was also mentioned this morning.

The other point which is also in this committee report, whether or not there is any wasted effort through failure of coordination between all of these clinics and between the various agencies.

Necrology Report

Since our last meeting there have departed from our ranks:

Dr. Karl O. Nielson, May, 1956;

Dr. Clarence R. Openshaw, November, 1955;

Dr. V. A. Christenson, March, 1956;

Dr. William H. Brooks, May, 1956;

Dr. Robert T. Jellison, May, 1956;

Dr. Leonard H. Tabaroff, April, 1956;

Dr. J. W. Williams—I am not sure of the date;

Dr. Russell W. Owens—I am not sure of the date;

And Dr. Kersey G. Riter.

We will bow our heads in a moment of prayer. Thank you.

Dr. Donald M. Moore then read a report by letter from Harvey T. Sethman, Managing Editor of the Rocky Mountain Medical Journal.

Resolutions

The following resolutions were then read by Dr. Snow, Chairman of the Resolutions Committee, and approved as follows:

Water Purification

"WHEREAS, previous committees have stimulated sufficient interest in the problems related to sanitary sewage disposal and hygienic pure culinary water supplies to have seen that the Utah State laws now provide adequate regulatory powers to correct the almost total inadequacy in most municipalities of the state prior to 1951; and,

"WHEREAS, 88 per cent of the municipalities of the state have water supplies approved conditionally and fewer than ten of these have acceptable sewage disposal facilities; and,

"WHEREAS, the matters of inspection, recommendations for correction, and initiation of legal processes enforcing these new laws rest with the Public Health Department of this state; and,

"WHEREAS, it has been brought to our attention that the greatest problem within the State Health Department is inadequate funds to hire and keep adequately trained personnel, especially sanitary engineers, and to maintain the facilities necessary to carry out the work required by the new public health law:

"BE IT RESOLVED, that the State Medical Association strongly recommend to the responsible public officers, officials, that the necessary funds be made available to allow immediate and unhindered action by the Public Health Department, as required by law.

"BE IT FURTHER RESOLVED, that in the interest of economy and improved public health activities of the greatest population areas of the state, the idea of full-time health units for Salt Lake and Weber County, working with the State Health Department, would be most effective in inspection, study and recommendation regards sewage, water and air pollution measures. Such departments would be able to work with local officials, lighten the load of the State Health Department, and lessen the dangers of too much central control."

Water and Sewage Disposal

"WHEREAS, 88 per cent of the municipal water supplies are approved conditionally, and fewer than ten of the state municipalities have acceptable sewage disposal facilities; and,

"WHEREAS, there exists in many communities conditions which possess inherent dangers of a serious outbreak of epidemic disease; and,

"WHEREAS, notable incidence of typhoid fever, acute dysentery, infectious hepatitis, etc., are known to have occurred during the past year in Utah communities:

"BE IT RESOLVED, that the President of the Association be empowered to appoint a committee or use on of the appropriate standing committees to make a thorough investigation of all the facts available and report back to the Council at an early date."

Practice of Radiology

"WHEREAS, the practice of radiology, anesthesiology, pathology and psychiatry are medical specialties, recognized as such by the American Medical Association, the respective specialty societies, the Utah State Medical Association; and,

"WHEREAS, in Utah the Intermountain Hospital Service Association undertakes payment of fees for such services when rendered by an employee of a hospital; and,

"WHEREAS, the Intermountain Hospital Service is organized for the purpose of providing hospitalization, not medical care, of subscribers; and,

"WHEREAS, it was originally intended when the Intermountain Hospital Service was organized, that coverage of radiological, pathological,

anesthesia and psychiatric services would be withdrawn from the hospital service coverage when and if a medical care program became effective; and,

"WHEREAS, the physicians of the Utah State Medical Association have formed and are operating the Utah Medical Bureau (Blue Shield), and provide coverage for all medical specialties, including those enumerated above; and,

"WHEREAS, in other states of the Union, medical coverage under Blue Cross has been transferred to Blue Shield; and,

"WHEREAS, it is contrary to the principles of ethics of the American Medical Association and the Utah State Medical Association for a corporation to engage in the practice of medicine; now therefore,

"BE IT RESOLVED, that the Utah State Medical Association hereby goes on record as being opposed to services rendered by private non-salaried physicians as being covered under Blue Cross contracts. And be it further

"RESOLVED, that the Utah State Medical Association hereby directs its officers and appropriate committees to enter into negotiations with appropriate Blue Cross representatives, for the purpose of effecting transfer of medical coverages under Blue Cross to Blue Shield contracts."

Care of Dependents of the Uniformed Services

"WHEREAS, on July 7, 1956, Public Law 569, 84th Congress, was signed by the President thereby authorizing the federal government to assume responsibility for the care of dependents of members of the uniformed services; and,

"WHEREAS, on December 14, 1955, the House of Delegates of the Utah State Medical Association designated the Medical Service Bureau of the Utah State Medical Association (Blue Shield) to administer this act in the State of Utah for and in behalf of the medical profession; and,

"WHEREAS, the implementation of this act is being effected on a national basis: now, therefore,

"BE IT RESOLVED, that the Utah State Medical Association reaffirm its previous stand of having Blue Shield act as its fiscal agent in the administering of this act. And be it further

"RESOLVED, that the Council of the Utah State Medical Association be authorized to negotiate a contract with the Department of Defense, said contract to embrace all the procedures and details to effect prompt payment to physicians and collection of fees from the federal government, including the actual cost of doctors' services together with a reasonable charge for handling thereof."

Care of Old Age Recipients

"WHEREAS, there are in the State of Utah approximately 10,000 old age recipients who are dependent upon the county in which they reside for their medical care; and,

"WHEREAS, the Utah State Medical Association recognized the necessity for an adequate program to provide medical care for those of this group who are unable to pay: now, therefore,

"BE IT RESOLVED, that the Council of the Utah State Medical Association be empowered to investigate and negotiate with the Utah State Welfare Commission regarding the care of these old age recipients. Be it further

"RESOLVED, that a copy of this resolution be sent to the Governor of Utah, the Chairman of the Utah State Welfare Commission, Chairman of the Utah State Legislative Council and the Utah Attorney General, members of the House of Representatives and the Senate, State of Utah, and the Welfare Department of the Church of Jesus Christ of Latter-Day Saints."

Medical Center

"BE IT RESOLVED, that the House of Delegates of the Utah State Medical Association endorse, subject to the following stipulations, the proposal to erect a University Hospital as part of the Medical Center on the University of Utah campus, and pledges continued aid and cooperation in the project. This approval is based on adherence to specific recommendations as follows:

1. That a new and adequate basic science building is more urgently needed than a University Hospital. It should have priority in current planning.
2. That the hospital should not exceed 200 beds in capacity. This size is considered adequate to meet the needs of teaching and research. We disapprove larger bed capacity because we feel it would impose an unnecessary burden upon Utah taxpayers and might eventually become a propaganda center for authoritarian or socialized medicine. We believe that the state should not go into the private practice of medicine to support the medical school any more than it should enter the private practice of law to support the law school or the private practice of accounting to support the school of accounting.
3. That we condemn the concept of a medical school staffed only by full-time teachers. The participation of a wide group of capable voluntary part-time teachers and their adequate academic recognition is regarded by the House of Delegates as essential to a good teaching program and as indispensable for full development of the Medical School to its proper stature of influence and leadership.
4. That full-time teachers of medicine should have no private patients except upon the written referral of practicing physicians. If care after initial consultation is to be continued by the full-time teachers, this be specified in writing by the referring physician.
5. That at least one-half of such limited bed capacity of the University Hospital as is available for private practice should be allocated to part-time faculty members. These private patients, whether of full-time or part-time staff members, should be used, like all other patients, without discrimination for teaching purposes.
6. That the Medical School should expand its loci of instruction to utilize better the available teaching material. It should cooperate freely with private hospitals in educational programs for interns and residents.
7. That a Medical Center be constructed only upon sound fiscal policies and with assurance that finances will be available to build and maintain such a center.
8. That a permanent board should direct the professional policies of the University teaching hospitals. Not less than one-half of the members of the policy making board should be practicing physicians appointed by the Council of the Utah State Medical Association, and we recommend the passage of any legislation necessary to insure this."

Probation of New Members

"WHEREAS, applicants for admission to County Medical Societies are frequently unknown to the membership and the applicant often does not know his responsibilities to the Society; and,

"WHEREAS, many factors and considerations other than credentials are of importance in determining an applicant's eligibility for membership; and,

"WHEREAS, the curriculums of many medical schools are deficient in instruction in medical ethics, medical economics, medico-legal responsibilities or jurisprudence and orientation for the beginning practitioner: Now, therefore,

"BE IT RESOLVED, that the House of Delegates of the Utah State Medical Association requests each component medical society in Utah to accept new members on a one-year probationary status. Be it further

"RESOLVED, that during the probationary year the member be required to attend one or more sessions, without cost, of instruction in the above mentioned subjects conducted by the Utah State Medical Association."

Practice of Radiology

"WHEREAS, the privilege to practice medicine is granted, by law, to individuals who meet certain requirements; and,

"WHEREAS, there is, in law or equity, **no** distinction between the practice of medicine in hospital or in a physician's private office; and,

"WHEREAS, coverage for accident and/or illness is being undertaken to an ever-increasing extent by various types of insurance; and,

"WHEREAS, certain insurance policies provide for payment of fees for radiological services **only** if rendered in a hospital; and

"WHEREAS, such restriction has the effect of causing the patient to refuse acceptance of radiological services because of enforced absence from usual vocation, or other reasons; and,

"WHEREAS, requirement that the patient receive services only in a hospital discriminates against private radiologists who engage only in office practice; and,

"WHEREAS, there is distinct danger that insurance companies, by requiring services to be rendered in a hospital, are stimulating and fostering a program of medical care which could be dominated or controlled by hospital groups; Now, therefore,

"BE IT RESOLVED, that the Utah State Medical Association hereby goes on record as being opposed to the requirements that patients having coverage under insurance be required to enter a hospital for the purpose of receiving radiological services when those services can be given without detriment to the patient in the office of a radiologist or other qualified and competent doctor of medicine.

"BE IT FURTHER RESOLVED, that the Utah State Medical Association hereby directs its officers and appropriate committees to pursue this matter with various insurance companies engaged in business in this state, to the end that discrimination against non-hospital radiologists or other qualified and competent doctors of medicine be stopped."

Payments by Insurance Companies

"WHEREAS, in many cases of liability, insurance companies reimburse patients directly; and,

"WHEREAS, it frequently happens that physicians have attended such patients; and,

"WHEREAS, physicians have no way of knowing when claims have been settled, and by the time they do learn that settlement has been made, the patient has utilized the money for other purposes; and,

"WHEREAS, physicians frequently find it impossible to collect from patients after insurance carriers have made settlement: Now, therefore,

"BE IT RESOLVED, that the Utah State Radiological Society requests the appropriate officers and/or committees of the Utah State Medical Association to investigate the feasibility of correcting this situation so that by conjoint draft or other means, physicians' names may appear as payee along with the claimant."

Resolution submitted by the Sewage, Water and Air Pollution Committee was presented and tabled.

Hospital Relations

"WHEREAS, during the past year meetings between representatives from the Utah State Medical Association and various hospital representatives have resulted in general agreement of the basic principles governing physician-hospital relations, as set forth by the American Medical Association, the American Hospital Association and the Utah State Medical Association resolution of 1955; and,

"WHEREAS, some of these principles as written are so far-reaching and indefinite in scope that certain specific problems concerning these relations have not been solved in any sense of the word; and,

"WHEREAS, representatives of both physician and hospital groups acknowledge their obligation to provide patient service of the highest possible quality in all fields and both must acknowledge failure to attain this goal in certain regions; and,

"WHEREAS, physician and hospital groups also recognize that this failure is based on differences of opinion concerning specific financial working arrangements which must be clarified and settled in the minds of all physicians regardless of the field or specialty in which they may practice before accord can be reached with hospital representatives: Now, therefore,

"BE IT RESOLVED, that the Utah State Medical Association disapproves of the formation of any physician-hospital arrangement whereby the hospital receives any portion of a physician's income derived from hospitalized patients who are referred to him by another physician for consultation or care. And be it further

"RESOLVED, that the Utah State Medical Association disapproved of the formation of physician-hospital arrangements providing for the remuneration to hospitals from physicians for office and/or other space utilized by physicians in the care of hospitalized patients. And be it further

"RESOLVED, that the Utah State Medical Association disapproves of a physician selling his services to a hospital or any other lay agency for a fixed salary or a fixed percentage or under any other arrangement whereby the hospital or other lay agency is permitted directly or indirectly to sell his services."

Procedural Changes Regarding Conduct of Business by the House of Delegates

"WHEREAS, the members of the House of Delegates of the Utah State Medical Association are called upon to make decisions of far-reaching character during the deliberation of that body; and,

"WHEREAS, the problems confronting the House of Delegates are becoming increasingly complex, frequently of very controversial character, and often present many-sided aspects; and,

"WHEREAS, in the past no clear and decisive means have been employed to obtain all the information in order that these problems could be solved most equitably to all concerned; and,

"WHEREAS, the usual practice of deliberating in legislative bodies such as the House of Delegates of the Utah State Medical Association is to refer problems to regularly constituted committees for (1) the taking of testimony pro and con regarding these problems and (2) making recommendations regarding the solution of these problems to the House of Delegates at a later meeting: Now, therefore,

"BE IT RESOLVED, that the annual meeting of the House of Delegates be extended over parts of at least two days, with an interim between the two sessions during which time the various committees of the Utah State Medical Association can take testimony regarding the resolutions that are submitted to them, and report back to the House their findings and recommendations on the basis of this testimony. And be it further

"RESOLVED, that the President of the Utah State Medical Association charge the Committee on Constitution and By-Laws to suggest some such changes in the Constitution and By-Laws as will be necessary to effect the above described changes."

Dr. Ray T. Woolsey: I am talking to the motion, that we have two separate sessions of the House of Delegates irrespective of whether it requires a Constitutional amendment or whether it can be done by Presidential enactment. I am in favor of two separate sessions of the House of Delegates.

The motion was seconded and adopted.

Dr. Porter: Tellers have been appointed. We will now have our report of the Nominating Committee by the Treasurer. You know that is now obligatory, to have a Nominating Committee for new officers. These are merely names that the Nominating Committee is presenting to you, but you can name a dozen others from the floor if you want to.

Dr. Alan P. Macfarlane: The Executive Committee has suggested the following for the office of President-elect, and if we follow the custom of years past, he would come from one of the component societies to the south and east of Salt Lake City:

Reed W. Farnsworth of Cedar City
Ralph E. Jorgenson of Provo
T. R. Seager of Vernal.

For Honorary President:

C. N. Ray of Salt Lake City.

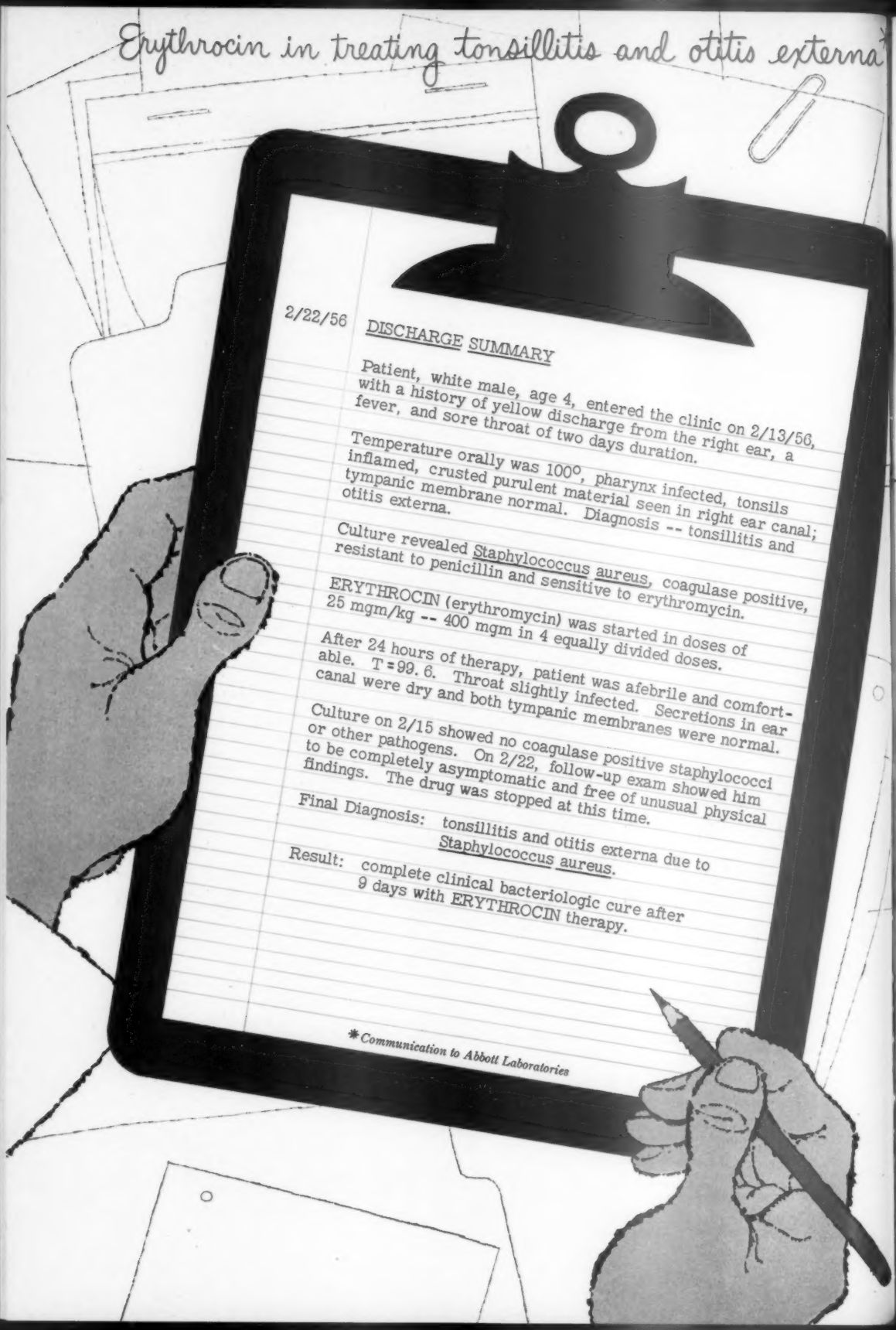
For Secretary to replace Dr. Donald M. Moore, who has regrettably had to resign, and for a two-year term, the balance of his term:

Juel E. Trowbridge of Bountiful
J. Poulson Hunter of Salt Lake City.

President Porter: Nominations are now open from the floor. President-elect, if any? (No response.) If there are none, for Honorary President? (No response.) For Secretary, two years, to succeed Dr. Moore? (No response.) I hear no nominations; therefore, the nominations are closed.

Dr. Charles Ruggeri: I want to say to the

(Continued on Page 1078)


Erythrocin in treating tonsillitis and otitis externa*
2/22/56 DISCHARGE SUMMARY
Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.
Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.
Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.
ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.
After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.
Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.
Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.
Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.
*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: ". . . *the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbott

® Filmtab—Film sealed tablets, Abbott; pat. applied for.

1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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Erythrocin® STEARATE

(Erythromycin Stearate, Abbott

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(Continued From Page 1075)

House of Delegates that the Presidency of the State Medical Association is becoming an extremely important and time-consuming job. It requires a lot of patience and a lot of skill and a lot of tact and a lot of everything you have got, plus a lot of time away from your office. I don't think that the association members realize the amount of time that is necessarily involved in the office of the Presidency, and it is getting more complicated, it is requiring more time all the time.

Now I want tonight to pay my respects to our President, Dr. Porter. I want to say that he has devoted himself unselfishly in your service. He has done an outstanding job. It has cost him money out of his pocket—I know. He has been away from his office a lot. We are proud of the work he has done. It is impossible to finish and complete all the work that one has in mind in a year; a year goes by so rapidly. And it does take time to accomplish these things.

Dr. Porter: It is my pleasure to present to you now the new President of the Utah State Medical Association. My association with Jim Davis over the past few years, as Councilor, then President-elect, and finally as President, convinces me that he is a man who is extremely capable of handling the hard duties that go with this office, and he will do them very, very well, that is, he will make friends. I think all of us know that Jim makes friends, people like him. If we can get our—I won't say enemies, because they aren't seeing eye to eye with us—to like him well enough, maybe we will get a little further along in the problems we are facing today. So, Jim, you are now the President. (Delegates stand and applaud.)

President James Z. Davis: Dr. Porter, it is customary in the Society to give you some small recognition for the services that you have performed, and it gives me great pleasure to make an award to you at this time.

I had thought sometimes that Dr. Porter daily grew in stature. I don't think he grew in stature, I just got to appreciate more and more the kind of a man he was. It gives me great pleasure, Dr. Porter, to present you this scroll and this gift which I hope you will find useful.

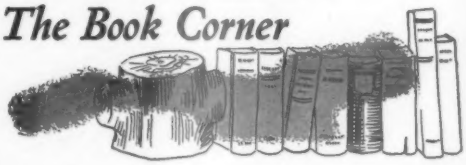
Dr. Porter: Thank you so much. I don't know what it is, but I am going to find it useful.

President Davis then gave his acceptance speech, which was published in the October, 1956, issue of the Rocky Mountain Medical Journal.

A motion was made, seconded and approved to hold the 1957 annual meeting in Salt Lake City.

A report from the tellers showed the following results: President-elect, Reed W. Farnsworth; Honorary President, C. N. Ray, and Secretary for two-year term, J. Poulson Hunter.

The Book Corner



New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Sleep, the Way to Sound and Healthful Slumber: By Dr. Marie Stopes, N.Y., Philosophical Library, 1956. Price: $3.00.

Observations on Krebiozen in the Management of Cancer: By A. C. Ivy, Ph.D., M.D., John F. Pick, S.B., M.M., M.D. and W.F.P. Phillips, M.D. Chicago, Henry Regnery Co., 1956. Price: $2.50.

Ciba Foundation Colloquia on Endocrinology, vol. 10: Internal Secretions of Pancreas. Boston, Little, Brown Co., 1956. Price: $7.00.

Ciba Foundation Colloquia on Ageing, vol. 2: Ageing in Transient Tissues. Boston, Little, Brown Co., 1956. Price: $6.75.

New Bases of Electrocardiography: By Demetrio Sodi-Pallares, M.D., with the collaboration in the English translation, of Royall M. Calder, M.D. St. Louis, Mosby, 1956. Price: $18.50.

Tunisia Faces the Future. Compliments of the Press and Information Division of the French Embassy. 1956.

Clinical Pathology: Application and Interpretation: By Benjamin B. Wells, M.D., Ph.D. 2nd edition. Phila., Saunders, 1956. Price: $8.50.

Diseases of the Heart: By Charles K. Friedberg, M.D. 2nd edition. Phila., Saunders, 1956. Price: $18.00.

Diseases of the Breast: By C. D. Haagensen, M.D. Phila., Saunders, 1956. Price: $16.00.

Book Reviews

The Management of Menstrual Disorders: By C. Frederic Fluhmann. Philadelphia, W. B. Saunders, 1956. Price: $8.50.

This book, as was the previous edition, is an excellent, thorough, complete and practical work for the practicing physician. It is free from the

padding so frequently found in medical books. The subject matter is brought up to date and the modern interpretations and evaluations are thoroughly aired. The illustrations are usual, but adequate.

JOHN R. EVANS, M.D.

A Handbook of Medical Hypnosis: By Gordon Ambrose and George Newbold. London, Bailliere, Tindall & Cox, 1956. Price: $5.00.

This is a treatise on the general subject of hypnosis as applied to the practice of medicine. It discusses briefly the use of hypnosis in the various fields of medicine where it would have the greatest application. It adds little to the literature available for the past ten years.

JOHN R. EVANS, M.D.

The Morphology of Human Blood Cells: By L. W. Diggs, Dorothy Sturm, Ann Bell. Phila., W. B. Saunders Company, 1956. Price: $12.00.

This is a good 181-page atlas of human blood cells directed primarily to medical technologists and medical students. It is well indexed and the descriptions of cells accurate. Miss Sturm has prepared excellent color plates of cells but as good as they are, they still depict cells in an idealized state. More photomicrographs in color would have helped the reader make the transition from the idealized cell of the color drawing to the cell actually visualized in the microscope.

A section on staining methods and a short bibliography are included.

GEORGE H. CURFMAN, JR., M.D.

Life Stress and Essential Hypertension; a Study of Circulatory Adjustments in Man: By Stewart Wolfe, M.D., and others. Baltimore, Williams & Wilkins, 1955. Price: $7.50.

Any study which purports to be of assistance in an understanding of, in the diagnosis of, or in the treatment of cerebrovascular disease, is important to all physicians. This study attempts to investigate the effect of stress in the development of essential hypertension. Since this disease underlies the high death rate, 90 per cent from cerebral hemorrhage, it is of particular interest to internists and neurologists. The stated purpose of this monograph is a review of the data in which circulatory adjustments are related to life experiences. The monograph is a report of the results of studies on cardiovascular function carried out in the past ten years in the laboratories of Cornell-New York Hospital, and include supplementary observations made in the Department of Medicine in the University of Oklahoma. The investigations were supported in part by research grants from the National Heart Institute and the Commonwealth Fund. Two hundred and sixteen patients with a variety of cardiovascular disturbances were followed in a specially staffed clinic. Although the cardiovascular disease patients were not selected for the presence of emotional problems, it was inevitable that a large number of such patients sought help in this clinic. All patients were studied with respect to background and life experiences, attitudes and aspirations. One hundred and thirty-five presumably healthy subjects served as controls for the various test procedures. In the case of many patients, a diary record with daily entries was kept. In this were recorded the events, attitudes and reactions which were correlated with the occurrence of symptoms of cardiovascular disturbances. One of the technics used was the so-called stressful interview. During such experimental test situations, topics of known threatening significance in the subject's life were introduced into a normal discussion while various test indicators of cardiovascular function were being recorded. The latter included the balistocardiograph, renal blood flow estimation, insulin clearance method, sphygmomanometric readings in either arm, contractile state of skin capillaries by the method of DiPalma's ring, clotting time, blood viscosity, funduscopic examination, venous pressure readings, circulation time, ausculation of the heart, and exercise testing.

It is the conclusion of the authors that antipressure drugs and surgical operations on various portions of the sympatho-adrenal system have not gone far toward solving the problem of therapy in essential hypertension. It is their opinion that the most promising therapeutic approach is toward the patient as a whole and his general life adjustment. It is admitted, however, that even in this approach the results of therapy are only suggestive. It is also admitted that the patho-physiologic processes in essential hypertension have not been significantly altered by any currently available therapeutic measures. From their studies of the effects of exercise on patients with essential hypertension, they stated that "It might be reasonable to suggest prescription rather than proscriptions of vigorous muscular effort in essential hypertension in those patients whose hearts are well-compensated and not enlarged." It is the impression of the reviewer that the authors have succeeded in demonstrating again, by means of various laboratory data, that cardiovascular functions in general are highly responsive to meaningful events, and that a host of arrythmias and peripheral vascular disorders are affected by such events. The reviewer does not agree with their belief that peripheral vascular disorders may arise largely from being highly responsive to meaningful events. The authors correctly point out that after more than fifty years of study with mechanical, chemical, and electrical tools, elucidation of mechanisms involved in essential hypertension is still incomplete. A laboratory corollary, as a matter of fact, which fits into the process of what we recognize as essential hypertension has not yet been conceived. The reviewer is not certain this can be devised. This is largely for the reason that essential hypertension is not understood. An interesting statement by the authors is that essential hypertension is mainly a diagnosis of exclusion made by most clinicians on the basis of repeated sphygmomanometric recordings with or without observations on the presence of any recognizable arteriolar lesions. A few patients after months or years, spontaneously lost their evidence of elevated arterial pressure. It was indicated, however, that this did not always corollate with improvement in the disease. It has been found that a normal blood pressure in a hypertensive sometimes occurs following stroke or a coronary occlusion. It is also found that arteriolar changes are progressive even after arterial pressures have returned to normal in some patients.

The significant contributions of the authors in this monograph relate to data which suggest, but by no means demonstrate or prove, that a proper mental point of view, namely, a more certain self-assertion, and the development of the capacity to make whole-hearted commitments, tends to improve or to place the essential hypertension patients in a state of remission.

GEORGE W. HOLT, M.D.

Textbook of Endocrinology, 2nd Edition: Edited by Robert H. Williams, M.D., F.A.C.P. W. B. Saunders Co., Phila.-London, 1955. Price: $13.00.

The new edition of Endocrinology is a clinician's text, giving a total picture of one of medicine's most rapidly expanding fields.

The first chapter deals with the general principles of endocrinology, since many of the basic functions of the endocrines are similar. In it are discussed the most important laws of endocrinology, with emphasis on the general action of hormones. In subsequent chapters detailed descriptions are given of the anatomy, physiology and chemistry of the various endocrine glands, along with discussion of clinical manifestations of diseases of these glands and procedures for establishing diagnosis.

Six chapters have been completely rewritten on the adrenals, ovaries, pancres, parathyroids, neuroendocrinology and obsesity.

A brand new chapter has been added on the Diagnosis and Treatment of Endocrinopathies; Hormone preparations. This book brings to the clinician a general discussion of how scientific principles are applied to clinical problems of endocrine disturbances.

The author evaluates and discusses such tests as: the protein-bound iodine, radioiodine tests, serum cholesterol, thyrotrophin test, ACTH response tests and many others.

W. BERNARD YEGGE, M.D.

The Prevention of Disease in Everyday Practice: By Isadore Givner, B.S., M.D., F.A.C.S., and Maurice Bruger, M.Sc., M.D., C.M., F.A.C.P., and Contributors. St. Louis, C. V. Mosby Co., 1955. 964 p. Price: $20.00.

This is a textbook urging the extension of preventive medicine to diseases other than infections, and the role of preventive medicine in them. The fields are covered by a number of contributors. It is a good, often thought-provoking, review of the subject. Most of us are still concerned chiefly with repair rather than prevention of disease. There are good sections on prevention of cancer, and accidental poisoning. Preventive cardiology is an interesting section, especially the comments on iatrogenic heart disease. Prevention of peripheral vascular diseases is well done. Prevention of pulmonary disease is the more important because cure is so difficult. There are interesting sections on gastroenterology, gastritis, tropical medicine, allergy, dermatology, general surgery, ophthalmology, urology, obstetrics and gynecology. There is even a section on dentistry, with discussions on prevention of caries, which is a problem that has received great public notice in recent years.

Generally speaking, the book is quite interesting, perhaps not always of a clinically practical nature, but it provides a glimpse into the future of medicine and certainly reflects a great void of knowledge yet to be filled.

AUSTIN MUTZ, M.D.

Handbook of Treatment: By Harold Thomas Hyman. Phila., J. B. Lippincott, 1955. 511 p. Price: $8.00.

The author, Harold Thomas Hyman, is the author of two other books, **Integrated Pratice of Medicine** and **Handbook of Differential Diagnosis.**

This **Handbook of Treatment** is a quick reference book prepared in such a way that the material is readily accessible. While the subject matter is largely that of therapy, there are also listings and short summaries of the salient features for diagnosis of the more common disease processes.

The format is very practical for a busy doctor, in that, at the top of each page, alongside the page number is the name of the therapy or disease appearing on that page. These are arranged alphabetically throughout the book. By this method one can quickly find what he is looking for by directly thumbing through rather than checking an index first for a page number. Two columns of subject material appear on each page which seems to expedite quick reference, and in those areas where indicated, tables have been prepared effectively.

The author feels that in these days of prescribing proprietory drugs, it is better to use trade names with the manufacturers, rather than the traditional U.S.P. nomenclature.

While in general the recommendations as to the treatment of choice might be questioned by some, it is thought that the book presents a ready and reliable source of reference. It might be said that this **Handbook of Treatment** is a king-size version of **Merck's Manual.**

It is the feeling of this reviewer, that this reference would be an asset to the quick-reference library of any man practicing clinical medicine.

E. KEITH DAVIS, M.D.

Bellevue Is My Home: By Salvatore R. Cutolo, M.D. Garden City, N. Y., Doubleday and Company, Inc., 1956. 317 p. Price: $4.00.

This is a fascinating, highly readable story of one of the world's most famous and well known hospitals. It is impossible for any one person to relate all the colorful, epoch-making and at times weird events that have happened in Bellevue Hospital, but Dr. Cutolo who has been an assistant superintendent in this institution for over a quarter of a century has done a remarkable job of presenting the picture.

I am sure this is a story which will appeal to almost any reader, but especially to those of us who have worked there. During the hospital days, with limited funds, many of us at Bellevue found it most interesting and inexpensive on days off, to select an interesting-looking character on one of the wards and spend the afternoon visiting. The stories were more fascinating, even if not always true, than any Broadway production. Many of these colorful personages are described by Dr. Cutolo.

The book is highly recommended for light interesting reading for both doctors and laymen.

CHAUNCEY A. HAGER, M.D.

Endogenous Uveitis: By Alan C. Woods, M.D. Baltimore, Williams & Wilkins, 1956. 303 p. Price: $12.50.

This is a comprehensive survey, excellently done, of a most difficult subject. There are 28 excellent colored plates and numerous microphotographs. The work is a continuation of the pamphlet used by the Academy of Ophthalmology and Otolaryngology, and has been revised, simplified and brought up-to-date.

The classification, etilology, pathology and treatment contains the latest knowledge concerning the subject, and has been well done. It is equally valuable for the student and practicing ophthalmologist.

J. LEONARD SWIGERT, M.D.

PROBLEMS IN MENTAL RETARDATION

We, as physicians, as a rule, are almost totally unaware of the problems of mental retardation. Yet there is no other problem, not even cancer, in which our understanding, guidance, encouragement, and moral support are more desperately needed than when parents come to face the fact that their child is retarded.

Our reaction has usually been: "Your child is retarded, he will probably not be educable, there is nothing we can do for him. Your best solution is to make out commitment papers in order to have him institutionalized at the earliest opportunity."

No remark could be more wrong, not only in crushing the parents' hopes and aspirations for their child, but also in prognostication.

The physician should be slow in diagnosis of retardation, except in the most obvious cases; a child may have physical characteristics suggestive of mongolism, for example, and yet follow a perfectly normal development pattern. Still we must be alert to recognize early any deviation from normal, as in the case of cretinism where early diagnosis and treatment prevent mental deficiency.

Neither should we hesitate to inform parents of doubts concerning the child's mentality, once he shows abnormal patterns of development.

Prognosis as to the ultimate amount of retardation is even more uncertain. There are as many degrees of retardation in mongolism as there are in other undifferentiated amentias. It is impossible to predict what mental age an infant will attain, as the psychometric tests available are unreliable prior to age three.

It has been found that the majority of retarded children can be cared for adequately in the home if the parents are willing to accept the responsibility and are anxious to further the welfare of their child. Only for the very severely retarded children should institutionalization be recommended, and then certainly not at the time the parents are first presented with the diagnosis of retardation.—Amy S. Barton-Blatt, M.D., in J. Am. Medical Women's Assn.

"MARCH OF MEDICINE" TV SHOW REPORTS ON MISSIONARY MEDICINE

The story of missionary medicine will be presented in a one-hour "March of Medicine" documentary telecast this month. The program will beamed to the general public over 75 stations of the NBC-TV network, Tuesday, November 27 at 9:30 p.m., EST, in place of the "Armstrong Circle Theatre." Check local newspapers for time of broadcast in your area.

Produced and sponsored by Smith, Kline and French laboratories in cooperation with the American Medical Association, this will be the first medical program of its kind to be televised in color. The program will follow the daily activities of Dr. John E. Ross who has served for the past eight years as a mission doctor in the Belgian Congo. Dr. Ross (a native Californian and graduate of the Indiana School of Medicine) spends 14 hours a day operating in native huts, traveling to distant bush clinics and caring for lepers in the leprosarium he established soon after arriving in Africa.

This is the second program in the "March of Medicine" series which explore the activities of medicine outside the United States. The first was a report on the effects of atomic radiation ten years after the dropping of the A-bomb in Hiroshima, Japan.

A special showing of the missionary medicine film will be presented the same evening — November 27 — at the AMA's 10th Clinical Meeting in Seattle.

STUDENT LOAN FUNDS GO BEGGING

The Rotary Club of Englewood, New Jersey, recently reported that its $11,500 loan fund for college students has not receive a single application for the past three years. Thirty other New Jersey Rotary Clubs report a similar experience. That this is a general phenomenon is attested to by many medical college deans whose student loan funds are currently being very little called upon.

One reason for this unprecedented situation may well be the general prosperity of the period and the fact that more parents than ever before are in position to finance their son's or daughter's education. An even more important reason, however, may be the one pointed out by William H. Sorter, chairman of the Englewood Rotary Club fund. He states, "There are so many sources of scholarship money, including the government and the universities, and youngsters are so accustomed to getting things for nothing, that none seems to be interested in scholarship loans."

It is indeed a peculiar phenomenon that while in this last fifteen years our citizens as a whole have been willing to increase their mortgage indebtedness for their homes from $17.3 billion to $82.1 billion, and their installment debt, mostly for household appliances and cars, from $5.5 billion to $24.9 billion, students have become progressively less willing to borrow to obtain the education which would almost certainly increase the earning capacity of their later years.

This situation should certainly give pause to those inclined to rush to the relief of that 50 per cent of high school graduates who are said to have the mental ability to go on to college but fail to do so "because of lack of funds."

If this lack is only a lack of free funds (scholarships) and the student does not have enough faith in himself and enough respect for what a college education can do for him, to lead him to apply for a student loan, is it not an open question if he deserves a higher education?—The Journal of Medical Education.

CARE OF ARMY MILITARY PERSONNEL AWOL

Recent changes to Army regulations provide, under certain conditions, for payment from Army funds of bills incurred for emergency treatment by soldiers in an AWOL status. This is a departure from previous policy which prohibited payments of bills for medical services rendered while in an AWOL status. The following is an explanation of the Army's policy:

In a number of cases physicians and hospitals have accepted for emergency treatment members of the Army who were in a status of absent without leave (AWOL). Upon subsequent submission of vouchers for payment, the physician or hospital has had to be informed that current regulations preclude the payment from public funds for medical treatment rendered military personnel in such a status.

Upon the acceptance by a hospital or physician of a member of the Army, immediate report should be made to the Army commander of the Area in which the civilian medical care is required, the chief or the military district of the area, the nearest Army post commander of the individual's commanding oficer, giving the individual's name, serial number, organization, military address, status, nature of illness or injury and statement of the practicability of transfer of the patient to an Army or other governmental hospital. This procedure should be accomplished whether the person is absent with or without official leave in order that his parent organization may be informed of his continued absence by reason of illness or injury. A similar report should be rendered if for any reason an unconscious patient is believed to be a member of the Army. On receipt of an acknowledgement from military authorities authorizing the civilian hospital or doctor to treat the case, the charges for medical care furnished AWOL personnel subsequent to receipt of the authorization may be paid. These statements apply to prctically every situation except when unauthorized medical care is furnished for a condition that is not an emergency.

Statements of account for payment may be forwarded to the individual's commanding officer, or the appropriate Army area surgeon, who will transmit them to their proper destination.

ALL ABOARD FOR AMA'S MEETING IN SEATTLE

AMA's 10th Clinical Meeting November 27-30 in Seattle will focus attention on the diseases and conditions most frequently met by America's family physicians. More than 2,500 physicians are expected to attend the meeting. Center of activities will be the Civic Auditorium where scientific sessions will be held and the more than 200 scientific and technical exhibits will be displayed. Headquarters for the House of Delegates and meetings of the Board of Trustees, councils and reference committees will be the Olympic Hotel.

Some 45 papers dealing with such varied subjects as fluid balance, urological problems, office psychiatry, varicose veins, fractures, diabetes and heart disease will be given by well-known physicians from all parts of the country. More panel discussions than ever before will be featured, including ones on: Problems of Prenatal Care; Problems of Aging; Care of the Cleft Lip and Palate Child by the Coordinated Team Approach; Late Complications of Chronic Liver Disease; Vascular Diseases; Pelvic Pain; Bleeding of Early and Late Pregnancy; Office Gynecology; Diagnostic and Therapeutic Problems of the Stomach and Duodenum; Fracture of the Long Bones; Congestive Heart Failure; Diabetes; Tranquilizing Drugs; Coronary Heart Disease; Surgical Treatment of Pelvic Malignancies.

Of particular interest will be a special exhibit on fractures and a manikin demonstration of problems of delivery. A group of exhibits has been assembled depicting the history of medicine in the Pacific Northwest, showing the contributions which doctors have made to the development of the area.

Both morning and afternoon color television clnics will be conducted on a variety of subjects. The medical motion picture program, however, will be held afternoons only, except for a special premiere showing Tuesday evening (November 27) of a new medicolegal film on the doctor as a medical expert witness.

BLUE SHIELD AND THE ECONOMICS OF MEDICINE

Why should any doctor take a special interest in his Blue Shield Plan?

For one thing, the physician has a vital professional stake in the success of his own medical prepayment Plan. This Plan demonstrates the doctor's determination to solve the basic problems of medical economies on terms that will assure him

a continuing opportunity to give his patients the best care he is capable of rendering.

Secondly, the Blue Shield Plan is accounting for an ever larger part of the doctor's income. He will want to make sure that Blue Shield provides him with reasonable payments for the services that Blue Shield promises to pay for.

Thirdly—and perhaps most important—only through Blue Shield can the medical profession continue to control the economy of medical practice.

Blue Shield pioneered the development of prepaid medical care. And, while many other agencies are now providing cash benefits for medical service on an expanding scale, only Blue Shield—because of its intimate relationship to organized medicine—is consistently endeavoring to relate its benefits to the physician's normal charges. Only Blue Shield—because of its non-profit organization—has as its basic purpose the provision of maximum sevice to the patient, with an adequate compensation to the doctor. Any profit derived from Blue Shield operations goes to the patient in broader benefits, or to the physician in more adequate payment—not to a third party.

If other organizations unrelated to the medical profession were to take over the entire voluntary pre-payment program, then control of the basic economy of American medicine would pass completely out of the hands of the medical profession.

Blue Shield has grown into a big business, in terms of the 37 million people enrolled and the more than $350 millions now paid each year in medical benefits by the Plans. But Blue Shield is big only because the medical profession has fashioned a big instrument to do a big job—and the public has given Blue Shield a big reception!

Blue Shield can never be bigger than the profession that created it. It is yours, doctors, to mould and shape as you will, for the greater good of the people you serve.

AUXILIARY LAUNCHES "TODAY'S HEALTH" DRIVE

Local Woman's Auxiliary groups are moving full steam ahead on the current TODAY'S HEALTH subscription drive. In keeping with the 1956-57 national campaign theme of "Increased Reception Room Readership," auxiliaries are urged to place the popular AMA health magazine in every physician and dentist office in the country.

AMA TO CO-SPONSOR MEDICO-LEGAL FILMS

A series of films on medico-legal problems will be produced by the pharmaceutical firm of William S. Merrell Co. of Cincinnati in cooperation with the AMA's Law Department. The first film dealing with the doctor as a medical expert witness — will be previewed next month (November) at the AMA's Clinical Session in Seattle. This film will be available for showings at state and county medical society meetings after December 15.

A good college health program consists of far more than caring for the immediate needs of sick and injured students and teaching them good health habits. It has the responsibility of preventing illness or injury when possible, keeping aware of sanitary and environmental conditions that may be harmful and making appropriate recommendations, serving as an educational center for dissemination of information that may favorably affect the health of the community, and referring patients to specialized services when needed. Dana L. Farnsworth, M.D., Bulletin NTA, May, 1956.

* * *

Current information indicates that there are somewhat less than 400,000 active tuberculosis cases in the United States at any one time, approximately one-third of which are hospitalized for tuberculosis, one-third are known cases at home, and one-third are undetected cases. Robert J. Anderson, M.D., Pub. Health Rep., Feb., 1956.

* * *

The most unfortunate feature of tuberculosis in elderly persons is that it usually has no distinctive symptom. The cough, sputum, dyspnoea, slight dyspepsia and a general feeling of lassitude are all put down to increasing years. It is only when sudden pain or haemoptysis occurs that the patient becomes alarmed and seeks advice. It is then that advanced, old-standing disease is found, and the damage done from the wide distribution of tubercle bacilli from this focus of infection over a number of years can be visualized. F. R. G. Heaf, M.D., J. Royal Inst. Pub. Health and Hygiene, Nov., 1955.

* * *

The least tangible but probably the most potent factor in the existing favorable trend in mortality from tuberculosis is the general improvement in the standard of living. Greater earning power has made possible more adequate nutrition and better housing. Reduction in the average size of families has reduced overcrowding, which in turn has lessened opportunities for the spread of infection. Where economic levels have continued high, tuberculosis rates have fallen; when war or famine has intervened they promptly rise. It is more than coincidence that the levels of tuberculosis throughout the world are closely related to the economic level of the populations concerned. Alton S. Pope, M.D., and John E. Gordon, M.D., Am. J. Med. Sciences, Sept., 1955.

Express *Your* Opinion, Doctor!

SEVERAL years study has been devoted by American Medical Association Councils and Committees to a revision of the Principles of Medical Ethics. Everyone has seemed agreed that revision is needed. To date, a majority appears in agreement that the Principles (bearing in mind that they are and should be *principles,* not detailed laws or regulations) are too wordy, include many statements that are not in fact principles but regulations, include too much discussion of courtesies and etiquette — in brief, that the authentic published Principles should be reduced to a brevity approaching that of the Ten Commandments.

Some physicians and a few county medical societies over the country are disagreeing, vociferously. Whether they represent a small or a large minority or whether they may conceivably represent a so-far silent majority that has yet to make itself heard is not known to your Editors.

This poses an important question, and one which will probably be voted upon, perhaps authoritatively answered, by the House of Delegates of the A.M.A. at the Seattle Clinical Session late this month — November 27-30, 1956.

The Journal A.M.A. and many other medical publications have published these proposals, but some of our Rocky Mountain readers may have missed them. So we reproduce them on the next page — the proposed *new* Principles of Medical Ethics. They seem highly abbreviated but their wording is still tentative.

Read these proposed Principles in full, Doctor. Compare them with the 1954 published booklet entitled "Principles of Medical Ethics of the American Medical Association, which should be in your own personal file (if not, the officers of every county medical society have them). Then, *express your own opinion.* Express it to your local and state officers, to your own A.M.A. Delegates. Or write a letter direct to "Council on Constitution and By-Laws, A.M.A., 535 North Dearborn Street, Chicago 10, Ill.", before November 20.

The A.M.A.'s Proposed Principles of Medical Ethics

Preamble. These principles are intended to serve physicians, individually or collectively, as a guide to ethical conduct. They are not laws; rather, they are standards by which a physician may determine the propriety of his own conduct. They are intended to aid physicians, in their relationships with patients, with colleagues, with members of allied professions and with the public, to maintain under God, as they have through the ages, the highest moral standards.

Section 1. The prime objective of the medical profession is to render service to humanity with full respect for both the dignity of man and the rights of patients. Physicians must merit the confidence of those entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continuously to improve their medical knowledge and skill, and should make available the benefits of their professional attainments.

Section 3. A physician should not base his practice on an exclusive dogma or a sectarian system, nor should he associate voluntarily with those who indulge in such practices.

Section 4. The medical profession must be safeguarded against members deficient in moral character and professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5. Except in emergencies, a physician may choose whom he will serve. Having undertaken the care of a patient, the physician may not neglect him. Unless he has been discharged, he may discontinue his services only after having given adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which will interfere with or impair the free and complete exercise of his independent medical judgment and skill or cause deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

Section 8. A physician should seek consultation in doubtful or difficult cases, upon request or when it appears that the quality of medical service may be enhanced thereby.

Section 9. Confidence entrusted to physicians or deficiencies observed in the disposition or character of patients, during the course of medical attendance, should not be revealed except as required by law or unless it becomes necessary in order to protect the health and welfare of the individual or the community.

Section 10. The responsibilities of the physician extend not only to the individual but also to society and demand his cooperation and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.

THE COLORADO STATE MEDICAL SOCIETY

MIDWINTER CLINICAL SESSION; FEBRUARY 19-22; SHIRLEY-SAVOY HOTEL; DENVER

OFFICERS—1956-1957

Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1957 Annual Session.

President: George R. Buck, Denver.

President-Elect: Gatewood C. Milligan, Englewood.

Vice President: C. Walter Metz, Denver.

Constitutional Secretary (three years): James M. Perkins, Denver, 1957.

Treasurer (three years): William C. Service, Colorado Springs, 1959.

Additional Trustees (three years): Lawrence D. Buchanan, Wray, 1957; Thomas K. Mahan, Grand Junction, 1958; Terry J. Gromer, Denver, 1958; Bernard T. Daniels, Denver, 1959.

(The above nine officers compose the Board of Trustees of which Dr. Buck is Chairman and Dr. Metz is Vice Chairman for the 1956-1957 year.)

Board of Councilors (three years): District No. 1: Osgoode S. Philpott, Denver, 1957; District No. 2: Roger G. Howlett, Golden, 1959; District No. 3: Harry C. Bryan, Colorado Springs, 1958; District No. 4: Paul R. Hildebrand, Brush, 1957; District No. 5: John D. Gillaspie, Boulder, 1957, Vice Chairman; District No. 6: Harvey M. Tupper, Grand Junction, 1958; District No. 7: Charles L. Mason, Durango, 1958; District No. 8: Herman W. Roth, Chairman, Monte Vista, 1959; District No. 9: Scott A. Gale, Pueblo, 1959.

Grievance Committee (formerly the Board of Supervisors) (two years): Duane F. Hartshorn, Chairman, Ft. Collins, 1957; Kenneth H. Beebe, Vice Chairman, Sterling, 1957; Freeman H. Longwell, Secretary, Denver, 1958; Lawrence W. Holden, Boulder, 1957; Robert C. Lewis, Jr., Glenwood Springs, 1957; James S. Orr, Fruita, 1957; Gordon H. Vandiver, La Junta, 1958; Robert H. Smith, Colorado Springs, 1958; George G. Balderson, Montrose, 1958; Ligon Price, Mt. Harris, 1958; Walter M. Boyd, Greeley, 1958; William N. Baker, Pueblo, 1957.

Delegates to American Medical Association (two calendar years): E. H. Munro, Grand Junction, 1957; (Alternate, Harlan E. McClure, Lamar, 1957); Kenneth C. Sawyer, Denver, 1958; (Alternate, Irvin E. Hendryson, Denver, 1958).

Speaker, House of Delegates: Carl W. Swartz, Pueblo; **Vice Speaker:** Frank B. McGlone, Denver.

Foundation Advocate: Walter W. King, Denver.

Executive Office Staff: Mr. Harvey T. Sethman, Executive Secretary; Mrs. Geraldine A. Blackburn, Executive Assistant; Mr. John W. Pompelli, Executive Assistant; 835 Republic Building, Denver 2, Colorado; Telephone AComa 2-0547.

General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

STANDING COMMITTEES

Committee on Constitution, By-Laws and Credentials (two years): C. C. Wiley, Longmont, 1957, Chairman; Robert C. Lewis, Jr., Glenwood Springs, 1957; John B. Farley, Pueblo, 1957; I. E. Hendryson, Denver, 1957; L. L. Hick, Delta, 1958; E. A. Elliff, Sterling, 1958; John L. McDonald, Colorado Springs, 1958; Robert B. Patterson, Loveland, 1958.

Health Education (two years): Jack D. Bartholomew, Boulder, 1957, Chairman; Lewis Barbato, Denver, 1957; John Lichty, Denver, 1957; Dwight Brigham, Greeley, 1957; Leland M. Corliss, Denver, 1958; Edwin T. Williams, Denver, 1958; Walter C. Herold, Colorado Springs, 1958; William S. Abbey, Fort Collins, 1958.

Subcommittee on School Health: Jack D. Bartholomew, Boulder, Chairman; Jackson L. Sadler, Fort Collins; William R. Sisson, La Junta; Douglas R. Collier, Wheatridge; Lex L. Penix, Denver.

Library and Medical Literature (two years): John R. Evans, Denver, 1957, Chairman; Alvin H. Dahl, Englewood, 1957; W. Grayburn Davis, Denver, 1958; Barton H. Campbell, Arvada, 1958.

Medical Education and Hospitals (two years): William A. Liggett, Denver, 1957, Chairman; Myron C. Waddell, Denver, 1957; James F. Hoffman, Fort Collins, 1957; Harry C. Bryan, Colorado Springs, 1958; C. W. Eisele, Denver, 1958; James P. Rigg, Grand Junction, 1958.

Subcommittee on Medical Student Loan Fund: J. Robert Spencer, Denver, Chairman; Robert S. Liggett, Denver; Walter M. Boyd, Greeley.

Medical Service (two years): Fred R. Harper, Denver, 1958, Chairman; W. Grayburn Davis, Denver, 1957; Roy L. Cleere, Denver, 1957; R. T. Daniels, Denver, 1957; William C. Black, Denver, 1957; William B. Condon, Denver, 1958; Robert K. Brown, Denver, 1958; Kester V. Maul, Denver, 1958.

Medical Service Subcommittees:

Blood and Tissue Banks: William D. Millett, Denver, Chairman; John R. Grow, Eugene C. Beatty, S. M. Prather Ashe, Alba B. Glassburn, Jr., Robert G. Bosworth, Jr., all of Denver.

Distribution of Physicians: Samuel P. Newman, Denver, Chairman; Jean H. Humphries, Delta; Hermann B. Stein, Denver; Ward C. Fenton, Rocky Ford.

Emergency Medical Services: Roy L. Cleere, Denver, Chairman; Marshall G. Nims, Thad P. Sears, Denver; George S. Maxwell, Boulder; James W. Lewis, Colorado Springs; James D. Stewart, Fort Collins; G. Paul Smith, Grand Junction; David W. Boyer, Pueblo; David R. Barglow, Trinidad; Douglas Collier, Wheatridge; J. Gordon Hedrick, Wray.

Hospital-Professional Relations: George R. Buck, Denver, Chairman; Gatewood C. Milligan, Englewood; Robert P. Harvey, Denver.

Indigent Medical Services: Fred R. Harper, Denver, Chairman; Jacob Horowitz, Denver; John S. Anderson, Pueblo.

Intra-Professional Insurance Problems: Kester V. Maul, Denver, Chairman; George L. Paltee, Robert L. Gunderson, Bennett W. Muir, Austin Mutz, Denver.

Medical Care of Veterans: Robert K. Brown, Denver, Chairman; W. Grayburn Davis, Carl W. Whistler, Denver; Autrey R. Croke, Colorado Springs; Walter M. Boyd, Greeley.

Physician-Nurse Relations: William C. Black, Denver, Chairman; Irving H. Schwab, Colorado Springs; Lloyd Florio, Robert M. Maul, Denver.

Prepayment Services: Robert P. Harvey, Denver, Chairman; James R. Blair, Gerald Maresh, Warren Tucker, George Tyner, Denver; Martin G. Van Der Schouw, Fort Collins; Carl W. Swartz, Pueblo.

Medicolegal (two years): C. S. Bluemel, Englewood, 1957, Chairman; John G. Gillaspie, Boulder, 1957; Fred H. Hartshorn, Denver, 1957; Samuel B. Childs, Denver, 1958; Horace G. Harvey, Jr., Denver, 1958; W. Walter Wasson, Denver, 1958.

Necrology (two years): Lumir R. Safarik, Denver, 1957, Chairman; George A. Unfug, Pueblo, 1957; Frances McConnell-Mills, Denver, 1958; E. H. Munro, Grand Junction, 1958.

Public Health (two years): John Zarit, Denver, 1[illegible] Chairman; L. W. Holden, Vice Chairman, Boulder, 1958; John S. Bo[illegible]g, Denver, 1957; Joseph E. Cannon, Denver, 1957; Joseph L. Glaser, Den[illegible] 1957; Valentin E. Wohlauer, Brush, 1957; Charley J. Smyth, Denver, 1957; Horace Campbell, Denver, 1958; Franklin G. Ebaugh, Denver, 1958; Jackson L. Sadler, Fort Collins, 1958.

Public Health Subcommittees:

Aging (formerly Geriatrics): Walter Vest, Jr., Denver, Chairman; Charles Massion, Cortez; Henry Cleveland, Denver; Roscoe Ackerly, Pueblo.

Alcoholism and Drug Addiction: Norbert Sherr, Denver, Chairman; Edward J. Delehanty, Denver.

Automotive Safety: Horace E. Campbell, Denver, Chairman; Edward H. Vincent, Colorado Springs; Harry C. Hughes, Douglas Macomber, Denver; J. Gordon Hedrick, Wray.

Cancer Control: Ervin A. Hinds, Denver, Chairman; V. E. Wohlauer, Brush; John S. Bouslog, H. Calvin Fisher, Denver; T. W. Halley, Durango; E. H. Munro, Grand Junction; Walter Boyd, Greeley; Lanning Likes, Lamar; Harold Low, Pueblo.

Subcommittee on Cancer Conference: John S. Bouslog, Denver, Chairman; James Lewis, Colorado Springs; John H. Amesse, Claude D. Bonham, F. H. Brandenburg, B. T. McMahon, Mordant E. Peck, Denver; Harold T. Low, Pueblo; Douglas Collier, Wheatridge; Alexis Lubeheneo, Kenneth C. Sawyer, Clinton S. Lyter, Denver.

Crippled Children: Edward L. Binkley, Jr., Denver, Chairman; James A. Johnson, Colorado Springs; Sidney Blandford, Earl Gardell, Denver; Jean McMahon Bremers, Englewood; Ted W. Miller, Pueblo; William F. Stanek, Denver; Harry C. Hughes, Denver.

Industrial Health: Joseph L. Glaser, Denver, Chairman; George Maresh, Denver, Vice Chairman; Lewis Benesh, William T. Boehm, R. Robert Cohen, Denver; David Boyer, Pueblo.

Maternal and Child Health: Mariana Gardner, Denver, Chairman; Richard K. Roos, Boulder; James Watson, Colorado Springs; Margaret E. N. Beaver, Grand Junction; Scott A. Gale, Pueblo; John W. McDonald, Sterling.

Mental Health: Franklin G. Ebaugh, Denver, Chairman; E. James Brady, Colorado Springs; Paul A. Draper, Colorado Springs; Lewis Barbato, Edward G. Billings, William R. Lipscomb, John M. Lyon, Denver; William R. Conte, Greeley; Frank H. Zimmerman, Pueblo.

Rehabilitation: Joseph E. Cannon, Denver, Chairman; Richard H. Mellen, Colorado Springs; Felice Garcia, Herbert S. Gaskill, Denver.

Rural Health: Valentin E. Wohlauer, Brush, Chairman; Henry Ziegel, Collbran; Monroe R. Tyler, Denver; Mason Light, Gunnison; Charles Cassidy, Monte Vista; George Balderston, Montrose; Leonard J. Farabaugh, Pueblo; Henry P. Thode, Fort Collins.

Sanitation: Roy L. Cleere, Denver, Chairman; Edward S. Miller, Denver, Vice Chairman; George Christie, Canon City; Ray Witham, Craig; Ham Jackson, Fort Morgan; Sherwin Johnston, La Junta; George S. Williams, Lamar; Robert Livingston, Glenwood Springs.

Tuberculosis Control: John Zarit, Denver, Chairman; L. W. Holden, Boulder; William F. Stone, Colorado Springs; Joseph E. Cannon, Leroy Elrick, Robert S. Liggett, Arthur Robinson, Denver; F. Menard Murray, Durango; Jackson L. Sadler, Fort Collins; W. K. Absher, Pueblo; H. M. Van Der Schouw, Wheatridge.

Public Policy (two years): Robert P. Harvey, Denver, 1958, Chairman; Harry C. Hughes, Denver, 1957, Vice Chairman; J. L. McDonald, Colorado Springs, 1957; Raymond R. Lanier, Denver, 1957; Eugene Wiege, Greeley, 1957; Harlan E. McClure, Lamar, 1957; Eugene B. Ley, Pueblo, 1957; Sidney Blandford, Denver, 1958; Jackson L. Sadler, Fort Collins, 1958; Lloyd Wright, Golden, 1958; Harvey Tupper, Grand Junction, 1958; Kenneth H. Beebe, Sterling, 1958; Ex-officio: George R. Buck, Denver, President; Gatewood C. Milligan, Englewood, President-Elect; James M. Perkins, Denver, Constitutional Secretary.

Public Policy Subcommittees:

Legislation: H. I. Barnard, Denver, Chairman; Cyrus W. Anderson, Robert L. Gunderson, Alba B. Glassburn, Jr., I. E. Hendryson, Kenneth C. Sawyer, Denver; John B. Farley, Pueblo.

THE COLORADO STATE MEDICAL SOCIETY

Publicity: Cyrus W. Anderson, Denver, Chairman; John S. Bouslog, William B. Condon, James Hutchison, Douglas Macomber, F. Julian Maier, Denver.

Weekly Health Column and Health Articles: Robert Gordon, Denver, Chairman; Donn R. Barber, Henry C. Cleveland, Stuart G. Dunlop, Robert V. Elliott, L. McCarty Fairchild, W. Stanford Foultz, Joseph B. McCloskey, Mordant E. Peck, Donald K. Perkin, A. I. Rowan, Jr., James E. Strain, Denver.

Rocky Mountain Medical Conference (five years): George P. Lingenfelter, Denver, 1957; L. Clark Hepp, Denver, 1958; H. Calvin Fisher, Denver, 1959; Fred Kuykendall, Eaton, 1960; William M. Covode, Denver, 1961.

Scientific Program (two years): Donald E. Newland, Denver, 1958, Chairman; Charley J. Smyth, Denver, 1957; H. Harold Friedman, Denver, 1957; John H. Darst, Greeley, 1957; Carl W. Swartz, Pueblo, 1957; Morgan Berthrong, Colorado Springs, 1958; Dale Atkins, Denver, 1958; Albert J. Kukral, Denver, 1958.

Subcommittee on Entertainment: Robert Bosworth, Denver, Chairman; William M. Covode, Henry C. Cleveland, Darius Darwin, John McAfee, Robert McCurdy, Denver.

SPECIAL COMMITTEES

American Medical Education Foundation: Frank B. McGlone, Denver, Chairman; Gerald Smith, Colorado Springs; R. E. Glehm, Thad Sears, Denver; T. W. Halley, Durango; J. C. Straub, Jr., Flagler; J. G. Merrill, Grand Junction; Walter Boyd, Greeley.

Blue Shield Fee Schedule Advisory Committee: Warren W. Tucker, Denver, 1957, ObG, Chairman; James R. Blair, Denver, 1958, ALR, Vice Chairman; Harry C. Hughes, Denver, 1957, Or; James A. Philpott, Denver, 1957, D; John D. Gillaspie, Boulder, 1957, A; John I. Zarit, Denver, 1957, Pul; Bradford Murphey, Denver, 1957, PN; George A. Unfug, Pueblo, 1957, R; Gatewood C. Milligan, Englewood, 1957, Arapahoe; Lloyd Wright, Golden, 1957, Clear Creek Valley; John Amesse, Denver, 1957, Denver; Robert C. Lewis, Jr., Glenwood Springs, 1957, Garfield; Fred A. Humphrey, Fort Collins, 1957, Larimer; Kenneth E. Prescott, Grand Junction, 1957, Mesa; Ernest G. Ceriani, Kremmling, 1957, Northwestern Colorado; William N. Baker, Pueblo, 1957, Pueblo; Fred D. Kuykendall, Eaton, 1957, Weld; William R. Coppinger, Denver, 1958, S; William R. Lipscomb, Denver, 1958, NS; Felice A. Garcia, Denver, 1958, PL; Donald E. Newland, Denver, 1958, U; Louis Faust, Denver, 1958, GE; Joseph L. Glaser, Denver, 1958, Ind; Edward B. Craven, Boulder, 1958, Boulder; Jerome L. Keefe, Cheyenne Wells, 1958, Eastern Colorado; Kon Wyatt, Canon City, 1958, Fremont; John M. Kehoe, Leadville, 1958, Lake; Richard B. Greenwood, Montrose, 1958, Montrose; Thurman M. Rogers, Sterling, 1958, Northeast Colorado; L. S. Sampson, Las Animas, 1958, Otero; Leo W. Lloyd, Durango, 1958, San Juan Basin; Herman W. Roth, Monte Vista, 1958, San Luis Valley; C. B. Wills, Denver, 1959, Pr; Hermann B. Stein, Denver, 1959, Anes; Edward John Swets, Denver, 1959, Oph; H. Dumont Clark, Denver, 1959, I; Wesley Van Camp, Pueblo, 1959, C; Leo Flax, Denver, 1959, Pd; Eugene Hildebrand, Denver, 1959, Path; Robert K. Brown, Denver, 1959, TS; Stephen B. Phillips, Salida, 1959, Chaffee; L. L. Hick, Delta, 1959, Delta; Kenneth E. Gloss, Colorado Springs, 1959, El Paso; J. M. Lamme, Jr., Walsenburg, 1959, Huerfano; Lee J. Bouchat, Trinidad, 1959, Las Animas; Paul Hildebrand, Brush, 1959, Morgan; H. E. McClure, Lamar, 1959, Prowers; J. Gordon Hedrick, Wray, 1959, Washington-Yuma.

Military Affairs: Robert Liggett, Denver, Chairman; Leo W. Lloyd, Durango; Jackson L. Sadler, Fort Collins.

SPECIAL REPRESENTATIVES

Representatives to Adult Education Council (two years): Samuel B. Childs, Denver, 1957; John H. Freed, Denver, 1958.

Representatives to Executive Committee of the Code of Cooperation: John S. Bouslog, Denver; Robert P. Harvey, Denver.

Representatives to Rocky Mountain Radio Council: John S. Bouslog, Denver; Robert K. Brown, Denver.

Representatives to Code of Cooperation Committee: William C. Service, Colorado Springs; Cyrus W. Anderson, John S. Bouslog, George R. Buck, Robert P. Harvey, James M. Perkins, Denver; Gatewood C. Milligan, Englewood; Mr. Harvey T. Sethman, Denver.

BOARD OF TRUSTEES SUBCOMMITTEES

Advisory to Auxiliary: Harry C. Hughes, Denver, Chairman; Samuel B. Childs, Denver; C. C. Wiley, Longmont.

Board of Trustees-Board of Regents Liaison: George R. Buck, Terry Gromer, Kenneth C. Sawyer, Denver; Gatewood C. Milligan, Englewood; Lawrence D. Buchanan, Wray.

Building Committee: William A. Liggett, Denver, Chairman; C. Walter Metz, Kenneth C. Sawyer, Denver.

Indoctrination Course for New Members: Fredrick H. Good, Denver, Chairman; Gilbert Hall, Paul K. Hamilton, Denver.

Industrial Relations: Robert T. Porter, Greeley, Chairman; Ervin A. Hinds, Denver; Leo W. Lloyd, Durango; William B. Condon, Denver; George A. Unfug, Pueblo.

MONTANA MEDICAL ASSOCIATION

OFFICERS—1956-1957

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1957 Annual Session.

President: Edward S. Murphy, Missoula.

President-Elect: John A. Layne, Great Falls.

Vice President: Herbert T. Caraway, Billings.

Secretary-Treasurer: Theodore R. Vye, Billings.

Assistant Secretary-Treasurer: Park W. Willis, Jr., Hamilton.

Executive Committee: Edward S. Murphy, Missoula, Chairman; John A. Layne, Great Falls; Herbert T. Caraway, Billings; Theodore R. Vye, Billings; Park W. Willis, Jr., Hamilton; George W. Setzer, Malta; John J. Malee, Anaconda.

Executive Secretary: Mr. L. R. Hegland, P. O. Box 1692, Office Telephone 9-2585, Billings.

Delegate to American Medical Association: Raymond F. Peterson, Butte; alternate, Paul J. Gans, Lewiston.

NEW MEXICO MEDICAL SOCIETY

75th ANNIVERSARY MEETING: MAY 15, 16, 17, 1957; SANTA FE

OFFICERS—1956-1957

Terms of Officers expire at the Annual Session in the year indicated. Where no year or term is indicated, the term is for one year only and expires at the 1957 Annual Session.

President: Stuart W. Adler, Albuquerque.

President-Elect: Samuel R. Ziegler, Espanola.

Vice President: James C. Sedgwick, Las Cruces.

Secretary-Treasurer: Lewis M. Overton, Albuquerque.

Executive Secretary: Mr. Ralph R. Marshall, 223-24 First National Bank Building, Albuquerque; telephone 2-2102.

Immediate Past President: Earl L. Malone, Roswell.

Councilors (three years): W. E. Badger, Hobbs, 1957; W. D. Dabbs, Clovis, 1957; W. O. Connor, Jr., Albuquerque, 1958; L. L. Daviet, Las Cruces, 1958; Aaron Margulis, Santa Fe, 1959; Junius A. Evans, Las Vegas, 1959.

Delegate to American Medical Association (two years): H. L. January, Albuquerque, 1958; Alternate: Earl L. Malone, Roswell, 1958.

Board of Supervisors: A. J. Jenson, Hobbs, Chairman, 1957; W. J. Hossley, Deming, Secretary, 1957; Milton Floersheim, Jr., Raton, 1957; George W. Prothro, Clovis, 1957; A. D. Maddox, Las Cruces, 1958; G. A. Slusser, Artesia, 1958; Louis Levin, Belen, 1958; Jack Dillahunt, Albuquerque, 1958.

New Mexico Physicians Service: H. M. Mortimer, Las Vegas, 1957; H. L. January, Albuquerque, 1957; Fred Hanold, Albuquerque, 1957; L. L. Daviet, Las Cruces, 1957; O. C. Taylor, Jr., Artesia, 1957; C. S. Stone, Hobbs, 1957; R. P. Beaudette, Raton, 1958; R. V. Seligman, Albuquerque, 1958; Wendell Peacock, Farmington, 1958; Omar Legant, Albuquerque, 1958; Allen Haynes, Clovis, 1959; W. L. Minton, Lovington, 1959; J. P. Turner, Carrizozo, 1959; U. S. Marshall, Roswell, 1959; J. W. Hillsman, Carlsbad, 1959; Executive Director, Mr. L. J. LeGrave, 212 Insurance Building, Albuquerque, Phone 3-3188.

NEW MEXICO MEDICAL SOCIETY

COMMITTEES

Nominating Committee: Chairman, Robert Friedenberg, Albuquerque; Junius Evans, Las Vegas; Albert S. Lathrop, Santa Fe; John F. Conway, Clovis; C. F. Bunch, Artesia; Leland Evans, Las Cruces.

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THE UTAH STATE MEDICAL ASSOCIATION

OFFICERS—1956-1957

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1957 Annual Session.

President: James Z. Davis, M.D., Salt Lake.

President-Elect: Reed W. Farnsworth, M.D., Cedar City.

Past President: R. O. Porter, M.D., Logan.

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Treasurer: Alan P. Macfarlane, M.D., Salt Lake.

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Councilor, Cache Valley Medical Society: C. C. Randall, M.D., Logan.

Councilor, Carbon County Medical Society: L. H. Merrill, M.D., Hiawatha.

Councilor, Central Utah Medical Society:

Councilor, Salt Lake County Medical Society: James F. Orme, M.D., Salt Lake.

Councilor, Southern Utah Medical Society:

Councilor, Uintah Basin Medical Society: T. R. Sager, M.D., Vernal.

Councilor, Utah County Medical Society:

Councilor, Weber County Medical Society: I. B. McQuarrie, Ogden.

Delegate to the A.M.A., 1955-57: George M. Fister, M.D., Ogden; **Alternate:** Elliot Snow, M.D., Salt Lake City.

Editor of the Utah Section of the Rocky Mountain Medical Journal: R. P. Middleton, M.D., Salt Lake.

COMMITTEES

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Industrial Health Committee: R. M. Muirhead, Chairman, Salt Lake;

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THE UTAH STATE MEDICAL ASSOCIATION

(Continued From Page 1088)

Rulon F. Howe, Ogden; Paul A. Clayton, Jr., Salt Lake; Drew M. Petersen, Ogden; James Z. Davis, Salt Lake; D. T. Madsen, Price; Wm. M. Gorshek, Price; S. W. Georges, Provo; Charles Ruggeri, Salt Lake; William A. Wilbur, Salt Lake.

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Advisory Committee to Woman's Auxiliary: James Z. Davis, Salt Lake; James H. Rasmussen, Brigham City; C. C. Randall, Logan; L. H. Merrill, Hiawatha; John B. Cluff, Richfield; James F. Orme, Salt Lake; R. G. Williams, Cedar City; T. R. Seager, Vernal; Ralph E. Jorgensen, Provo; I. Bruce McQuarrie, Ogden.

Necrology Committee: L. A. Stevenson, Salt Lake; Leland K. Cullimore, Provo.

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Building Committee: Charles Ruggeri, Jr., Chairman, Salt Lake; James Z. Davis, Salt Lake; I. Bruce McQuarrie, Ogden; Philip B. Price, Salt Lake.

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THE WYOMING STATE MEDICAL SOCIETY

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Vice President: L. Harmon Wilmoth, Lander.

Secretary: Benjamin Gitlitz, Thermopolis.

Treasurer: C. D. Anton, Sheridan.

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Alternate Delegate, A.M.A.: B. J. Sullivan, Laramie.

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Gottsche Estate: Franklin D. Yoder, Chairman, Cheyenne; Karl Krueger, Rock Springs; O. K. Scott, Casper; Nels Vicklund, Thermopolis.

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THE WYOMING STATE MEDICAL SOCIETY

the Delegation from Northeastern Society; Chairman of the Delegation from Sheridan County.

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Parliamentarian: H. B. Anderson, Casper.

Laboratory and Blood Bank Committee: Donald Becker, Chairman, Casper; William Franz, Newcastle; Mark Watson, Worland; Sam Zuckerman, Cheyenne.

Historical Committee: Francis A. Barrett, Chairman, Cheyenne; William Hinrichs, Douglas; James W. Sampson, Sheridan; Franklin D. Yoder, Cheyenne.

Constitution and By-Laws Committee: H. B. Anderson, Chairman, Casper; William Hinrichs, Douglas; Ted Holman, Casper; William Rosene, Wheatland.

Cardiovascular and Renal Diseases: A. J. Allegretti, Chairman, Cheyenne; Lloyd Evans, Laramie; Charles Lowe, Casper; Seymour Thickman, Sheridan.

Arthritis Committee: Myron Harrison, Chairman, Rock Springs; David M. Flett, Cheyenne; Chester Ridgway, Cody.

Blue Shield Fee Schedule Committee: Anesthesiology: Lathan B. Lawton, Casper; Alternate: Charles H. Moore, Cheyenne; General Surgery: John B. Gramlich, Cheyenne; Internal Medicine: Lloyd R. Evans, Laramie; Neuropsychiatry: Don W. Herrold, Cheyenne; Obstetrics & Gynecology: Bane T. Travis, Cheyenne; Alternate: Robert H. Bowden, Casper; Opthalmology: O. L. Veach, term expires 1957, Sheridan; J. G. Wanner, term expires 1958, Rock Springs; R. D. Tebbet, term expires 1959, Casper; Orthopedics: Gordon Whiston, Casper; Otolaryngology: Charles R. Kudolla, term expires 1958, Casper; Pathology: S. S. Zuckerman, Cheyenne; Pediatrics: Robert M. Fowler, Casper; Radiology: James W. Barber, Cheyenne; Urology: Joseph E. Clark, Casper; General Practitioners: Albany County, B. J. Sullivan, Laramie; Carbon County, R. A. Corbett, Saratoga; Converse County, E. Geo. Johnson, Douglas; Fremont County, Bernard Stack, Riverton; Goshen County, Joseph R. Volk, Torrington; Alternate: O. C. Reed, Torrington; Laramie County, S. J. Glovale, Cheyenne; Natrona County, K. N. Roberts, Casper; Sheridan County, Louis Booth, Sheridan; Sweetwater County, John P. Muir, Rock Springs; Uinta County, J. H. Holland, Evanston; Northeast Wyoming, E. J. Guilfoyle, Newcastle; Northwest Wyoming, John F. Froyd, Worland.

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*Elected Commmittee Members.

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OFFICERS—1955-1956

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President-Elect: Sister Mary Jerome, Mercy Hospital, Denver.

Vice President: Hubert Hughes, General Rose Memorial Hospital, Denver.

Treasurer: M. A. Morita, Denver General Hospital, Denver.

Executive Secretary: Richard P. Mac Leish, Denver.

Executive Offices: 1422 Grant Street, Denver 3.

Trustees: Robert A. Pontow (1956), University of Colorado Medical Center, Denver; Roy Prangley (1956), St. Luke's Hospital, Denver; Magr. John R. Mulroy (1956), Catholic Charities, Denver; Roy Anderson (1957), Presbyterian Hospital, Denver; Harry Clark (1957), Southwest Colorado Memorial Hospital, Cortez; Elton A. Reese (1957), Alamosa Community Hospital, Alamosa; Louis Linwood (1958), National Jewish Hospital, Denver; Charles K. Levine (1958), Beth Israel Hospital, Denver; C. F. Fielden, Jr., (1958), Memorial Hospital, Colorado Springs; Louis I. Miller, M.D. (ex-officio), Colorado Hospital Service, Denver.

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GOOD WYOMING town for G.P. Good office space at reasonable rent. Phone Mr. Garlett, FL. 5-2327 or write 221 So. Eudora, Denver, Colorado.

AMA PREPARES LIST OF HEALTH FILM SOURCES

Medical society program and public relations chairmen will be especially interested in the booklet entitled, "A List of Sources of Films on the Subject of Health," recently prepared by the AMA'S Council on Scientific Assembly. The list includes the sources of motion pictures on the subject of health which have come to the Council's attention. The booklet is arranged in three parts: (1) loan, rental and sales libraries; (2) state health depatrment film libraries; (3) catalogs and special film lists. For complete listings of films, physicians should write directly to the sources listed. Copies of this booklet may be obtained from Motion Pictures and Medical Television, AMA.

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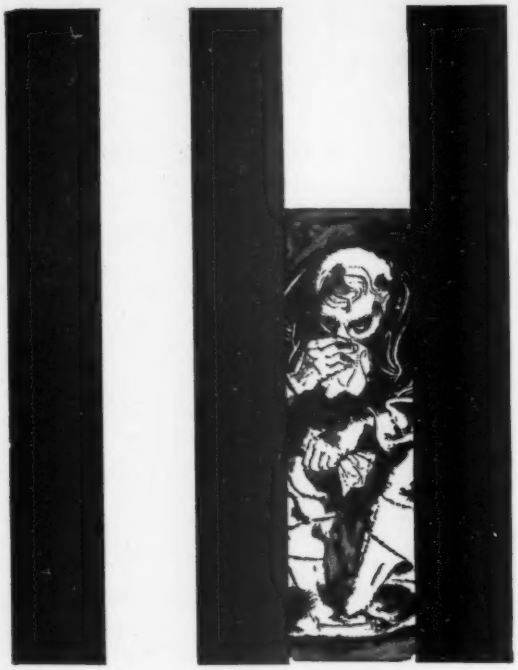

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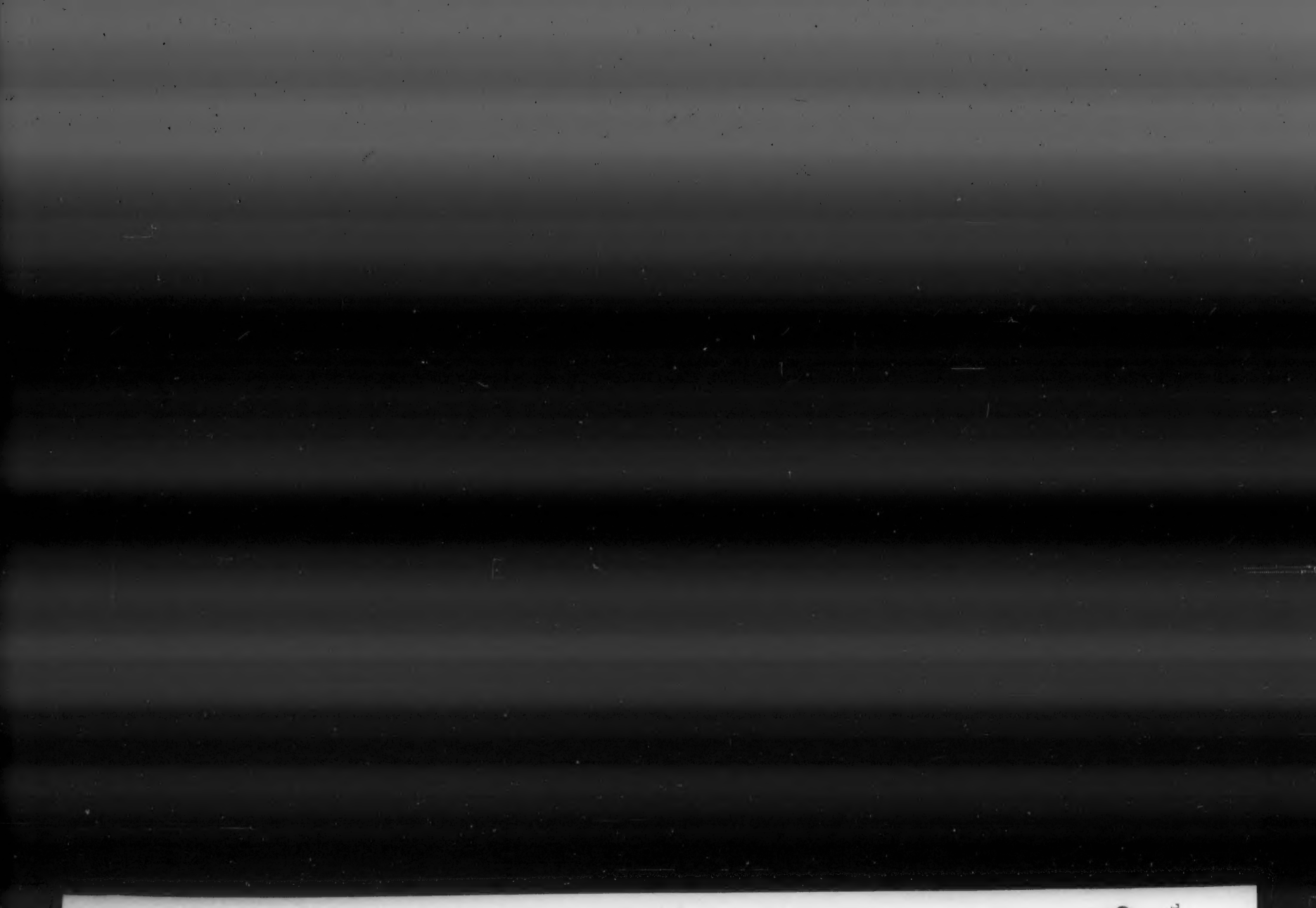

greater antibacterial efficacy...

Chloromycetin®

for today's problem pathogens

Because of the increasing emergence of pathogenic strains resistant to commonly used antibiotics, judicious selection of the most effective agent is essential to successful therapy. *In vitro* sensitivity studies serve as a valuable guide to the antibiotic most likely to be most effective. Both clinical experience and sensitivity studies indicate the greater antibacterial efficacy of CHLOROMYCETIN (chloramphenicol, Parke-Davis) treatment for many resistant infections.[1-7]

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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aph is adapted
ltemeier, Cul-
Sherman, Cole,
& Fultz.[1]

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